

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ETHEL ELIZABETH MacDermott</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 6, 1980</b>			2b. HOUR <b>11:15 P</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 30, 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Timonium</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Whispering Hill Apartments.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>21093</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Mistywood Circle Building 5 Apt. C</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob Meyers</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Molly Reuer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-----</b>		17. INFORMANT ADDRESS <b>278-50-0912 E. June Smith 2201 Pottspring Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Atherosclerotic cardiovascular disease</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>7</b> 19 <b>79</b> , to <b>3/6/</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>12</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>John W. Bowie M.D.</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3/7/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John W. Bowie, M.D.</b>						22e. ADDRESS <b>500 West University Pkwy.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/8/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County, Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>William E. Johnson 8521 Loch Raven Blvd.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 7 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McBrady</b>	

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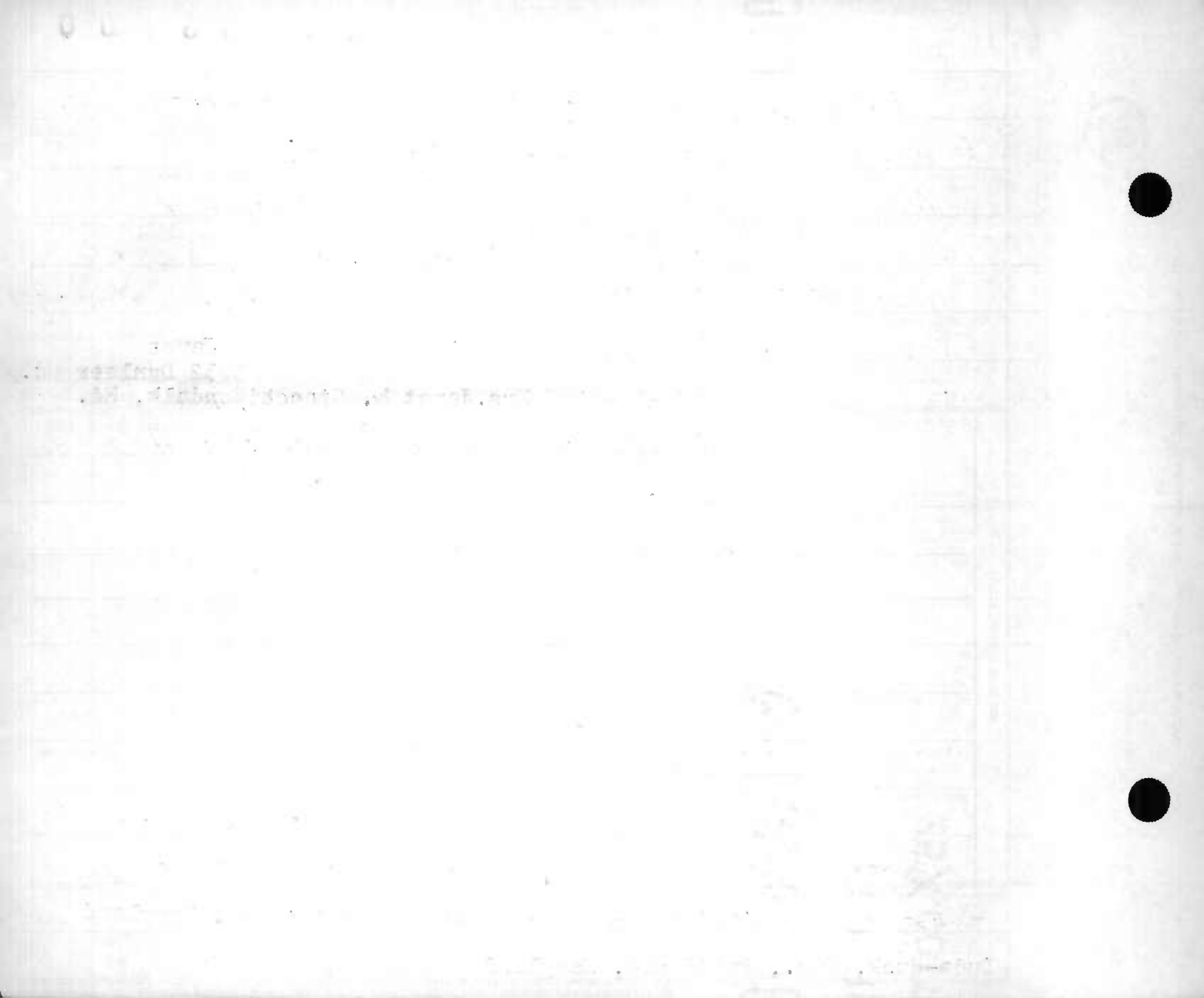
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Florence ANN Mahon</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-21-80</b>			2b. HOUR MIN. <b>6:10 P</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-25-04</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>75</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b>			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Stella Maris Hospice</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6911 Dunmanway Ct</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John J. Durr</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah James</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-24-6297</b>		17. INFORMANT <b>Mrs. Janet M. Ciocchi</b>				ADDRESS <b>3032 Dunleer Rd. Dundalk, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>40 minutes</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/28</b> , 19 <b>80</b> , to <b>3/21</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>3/17</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>E. Lee Robbins</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>3-21-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. Lee Robbins</b>				22e. ADDRESS <b>1205 York Rd. Lutherville 21093</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/25/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck, Inc., Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McBurney</b>			





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		20. DATE OF DEATH MONTH DAY YEAR				2b HOUR	
ETHEL V. MAJOR				March 19, 1980				M	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female		White		October 4, 1911		68		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		U.S.A.				Baltimore County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		6734 Charles Street Avenue		Owner		Restaurant			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
13a. STATE		Baltimore		Towson				6734 Charles Street Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Emery Hartman		Maretta Leonard							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		212-16-9346		Mr. Donald W. Major 6734 Charles Street Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA of PANCREAS</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
1579 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>none</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
10-30-79		Biliary obstruction							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				none					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>Oct 23</u> , 19 <u>79</u> , to <u>Mar 19</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>March 18</u> , 19 <u>80</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
<u>C. E. ELLICOTT M.D.</u>								3/19/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
C. E. ELLICOTT M.D.		1134 York Rd Lutherville MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Entombment		3-22-1980		Druid Ridge		Pikesville Maryland			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Ruck Towson Funeral Home, Inc. Towson, Maryland		1050 York Road		MAR 31 1980		<u>Patricia Hebrady</u>			



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 8 0 0 6 1 0 2									
1. DECEASED NAME (TYPE OR PRINT) <b>Florence Erma MALONE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>3 21 80</b>		2b. HOUR <b>7:00</b> <small>a</small>		
3 SEX <b>F</b>		4 RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5/4/95</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS		7 UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> <small>MD</small>			
10 CITY OR TOWN OF DEATH <b>ROSSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQ</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HSWE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3507 E. GOUGH ST</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>WESLEY</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNK</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO <b>UNK</b>		17 INFORMANT ADDRESS <b>THOMAS BLACKBORN NEW CUT RD 6826</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia; congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/11/80</b> to <b>3/21/80</b> , that (I) (we) lost saw the deceased alive on <b>3/21/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Michael Koger</b> <small>MD</small>					DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/21/80</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael Koger, M.D.</b>					22e. ADDRESS <b>9000 Franklin Square Drive</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/24/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOW RIDGE</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>J.G. CONNELLY 300 MACE</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Michael K. Brady</b>		

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>FRANK J. MANLEY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>03-31-80</b>				
3. SEX <b>Male</b>					2b. HOUR <b>3:49PM</b>				
4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 22, 1904</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St Joseph Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hecht Co</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13e. STREET ADDRESS <b>513 N. Curley St 4/1</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Manley</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Bruckhoff</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. <b>212-09-4644</b>		17. INFORMANT ADDRESS <b>Mrs Anna J Manley Same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ANTERIOR WALL MYOCARDIAL INFARCTION</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ANTERIOR WALL MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>Mar 23 1980</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (he) (this hospital) attended the deceased from <b>Mar 23 1980</b> to <b>Mar 31 1980</b> , that (he) (we) lost <b>Mar 31 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>M.D.</b>					DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>3.31.80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. KLEEMAN</b>					22e. ADDRESS <b>7600 OSLER DRIVE, TOWSON 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/4/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>APR 1 1980</b>	
24. FUNERAL DIRECTOR NAME <b>Leonard J Ruck Inc. Baltimore, Maryland</b>					25. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Thomas J. Manuccia			2a. DATE OF DEATH MONTH DAY YEAR March 4, 1980			2b. HOUR 11:20 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 13, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Middle River 21220		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1 Aquia Place				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Construction		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. COUNTY Baltimore		13d. CITY OR TOWN Middle River		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET ADDRESS 1 Aquia Place 21220	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Manuccia				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Concetta Speciale						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI		17. INFORMANT Ann Manuccia, Wife				ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF <u>Carcinoma of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 mo</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>March 4, 1980</u> to <u>March 4, 1980</u> , that (I) (we) lost saw the deceased alive on <u>MARCH 4, 1980</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Patricia A. Greve MD</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED 3-6-80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA A. GREVE						22e. ADDRESS 9101 FRANKLIN SQ. DRIVE				
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 3-8-80		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.			
24. FUNERAL DIRECTOR NAME Prudzinski Funeral Home PA 1407 Old Eastern Ave						25a. DATE REC'D. BY REGISTRAR MAR 7 1980		25b. REGISTRAR'S SIGNATURE <u>Patricia A. Greve</u>		







1 - FOR  
STATE  
REGISTER

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

006105

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MYRTLE E. MARANTO			2a. DATE OF DEATH MONTH DAY YEAR 3 31 80		2b. HOUR 3:45A <sub>M</sub>
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7-31-42	6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Arcadia Mfg. Co.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Balto. 13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Herman G. Gunter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Davis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Robert A. Maranto - 5835 Westwood Ave. -21206	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF BREAST TO 1749 } DUE TO, OR AS A CONSEQUENCE OF HEPATIC VEIN WITH Conditions, if any, which } (b) THROMBOSIS OF THE PORTAL VEIN AND gave rise to immediate } DUE TO, OR AS A CONSEQUENCE OF VENA CAVA cause (a), stating the } underlying cause last. } (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital attended the deceased from MARCH 7, 1980, to MARCH 31, 1980, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on MARCH 31, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE SMUEL C.H. LEE MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SMUEL C.H. LEE MD		22e. ADDRESS 7620 YORK RD. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-3-80	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.
24. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206			25a. DATE REC'D. BY REGISTRAR APR 3 1980		
			25b. REGISTRAR'S SIGNATURE		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
JOSEPH A. MARSIGLIA					03 14 80					2:15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS	
Male		White		Feb 23, 1921		59 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				TOWSON MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
BALTIMORE		6701 N. CHARLES STREET GPMC								Cook	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		14. INSIDE CITY LIMITS?		15. STREET ADDRESS			
Maryland		Baltimore		Parkville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3214 Willoughby Rd			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
Vincent Marsiglia					Anna Vinci						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS					
Yes		WW 11		219-01-1024		Mrs Emma G Marsiglia		Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST											
1889 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) METASTATIC CA. OF BLADDER											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			21g. CITY OR TOWN		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET			COUNTY STATE		
						03/07 80			03/14 80		
22a. I certify that (I) (this hospital) attended the deceased from 03/14 19 80, to 03/14 19 80, that (I) (we) last saw the deceased alive on 03/14 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
Saul Shureih						MD			03/14/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
DR. S. SHUREIH						GREATER BALTIMORE MEDICAL CENTER					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
Burial			3/18/80		Lakeview			Baltimore, Maryland			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME Leonard J Ruck Inc. Baltimore, Maryland						ADDRESS			MAR 17 1980		

JOSEPH

W. J. L. L.

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WILSON

6701 N. CHARLES STREET

BALTIMORE

CARDIO RESPIRATORY ARREST

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DR. S. S. CHURCHILL

CLINICAL RESEARCH CENTER

MAR 17 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 006107			
1. DECEASED NAME (TYPE OR PRINT) <b>ELSIE W. MARTIN</b>					2a. DATE OF DEATH MONTH <b>3</b> DAY <b>3</b> YEAR <b>80</b>			
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH <b>2</b> DAY <b>19</b> YEAR <b>12</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>68 YRS</b>		7b. HOUR <b>10.30 PM</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD		
10 CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Westminster</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>726 Oak Tree Road</b>
14 FATHER'S NAME FIRST <b>John</b> MIDDLE <b>C.</b> LAST <b>Dyke</b>				15 MOTHER'S MAIDEN NAME FIRST <b>Edith</b> MIDDLE <b>Muse</b> LAST <b>Muse</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-01-9409</b>		17 INFORMANT ADDRESS <b>Marie E. Snyder 6435 Gilmore St. Balto., MD 21207</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b> <b>436-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):								
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>-</b> <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>-</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>-</b>		21f. LOCATION STREET <b>-</b> CITY OR TOWN <b>-</b> COUNTY <b>-</b> STATE <b>-</b>				
22a I certify that (if this hospital) attended the deceased from <b>3-1-1980</b> to <b>3-3-1980</b> , that (we) last saw the deceased alive on <b>3-3-1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>3-3-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. SUDHIR PATEL</b>				22e. ADDRESS <b>Bal. County Gen. Hosp Old Court Rd. Randallstown MD 21133</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>March 6, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Baltimore</b> STATE <b>Maryland</b>		
24 FUNERAL DIRECTOR <b>Loring Byers Funeral Directors, P.A.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 4 1980</b>				
8720 Liberty Road Randallstown, Maryland 21133				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Grace Adele MASON			2a. DATE OF DEATH MONTH DAY YEAR 3 25 80			2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 14, 1886		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care - Ruxton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None	
12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 3838 Roland Avenue							
14. FATHER'S NAME FIRST MIDDLE LAST Lucien Stoddard				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lavinia Pease			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 372-28-0346D 375-16-2770		17. INFORMANT Daughter: Eleanor M. Mason, 192 Hollen Road, Balto. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 2859 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic cardiac vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anemia</u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12, 29</u> , 19 <u>78</u> , to <u>March 25</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Walter T. Kees, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WALTER T. KEES</u>				22e. ADDRESS <u>Monkton, Md. 21111</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/25/80		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Catonsville Balto., MD</u>	
24. FUNERAL DIRECTOR NAME STEWART & MOWEN CO., 108 W. North Ave. 21201				25a. REC'D BY REGISTRAR APR 11 1980			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>MARGARET MAYER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 07 80</b>			2b. HOUR <b>4:15</b> M.				
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 11 1894</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>---</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.				
10 CITY OR TOWN OF DEATH <b>RELAY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1534 S. ROLLING ROAD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>RELAY</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1534 S. ROLLING ROAD, 21227</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>HENRY DOMEIER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH EAGERS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-32-1096</b>		17 INFORMANT <b>HENRY L. MAYER</b>		ADDRESS <b>ELLICOTT CITY, MD. 3709 FOLLY QUARTER ROAD</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Vascular Disease</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Diffuse atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b> <b>5-6 yrs</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>---</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <b>Sept 17</b> , 19 <b>79</b> , to <b>March</b> , 19 <b>80</b> , that (1) (we) last saw the deceased alive on <b>March 6</b> , 19 <b>80</b> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.										
22b. SIGNATURE <b>B.B. Brumbaugh M.D.</b>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/8/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. BRUCE BRUMBAUGH, M.D.</b>				22e. ADDRESS <b>5825 MAIN STREET, ELKRIDGE, MARYLAND 21227</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>03-10-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>				
24 FUNERAL DIRECTOR NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 11 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
GEORGIA			3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	
F.			White			12			30			1885	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Florida			USA						Baltimore County			Homemaker	
11. CITY OR TOWN OF DEATH			12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN	
Randallstown			Baltimore County General Hospital			MD			Baltimore			Pikesville	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT	
Efrin			Julia			No			262-80-2674JI			Mrs. Julia Michel	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
Pneumonia									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF										
486-			(b) Old age										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF										
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED			21e. PLACE OF INJURY	
			HOUR A.M. MONTH DAY YEAR						21f. LOCATION			CITY OR TOWN	
			P.M. 19						STREET			COUNTY	
									STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/15/1980 to 3/27/1980, that (I) (we) lost saw the deceased alive on 3/27/1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE			DEGREE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS	
Srinivas						3/27/80			SRINIVAS MD			Baltimore County Gen Hosp	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			23e. STATE	
Burial			4/2/80			Lake View Cemetery			Sanford			Seminole Florida	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. REGISTRAR'S SIGNATURE			25d. REGISTRAR'S SIGNATURE	
Loring Byers Funeral Directors, P.A.			MAR 28 1980			Loring Byers			Loring Byers			Loring Byers	
8728 Liberty Rd., Randallstown, MD 21133													



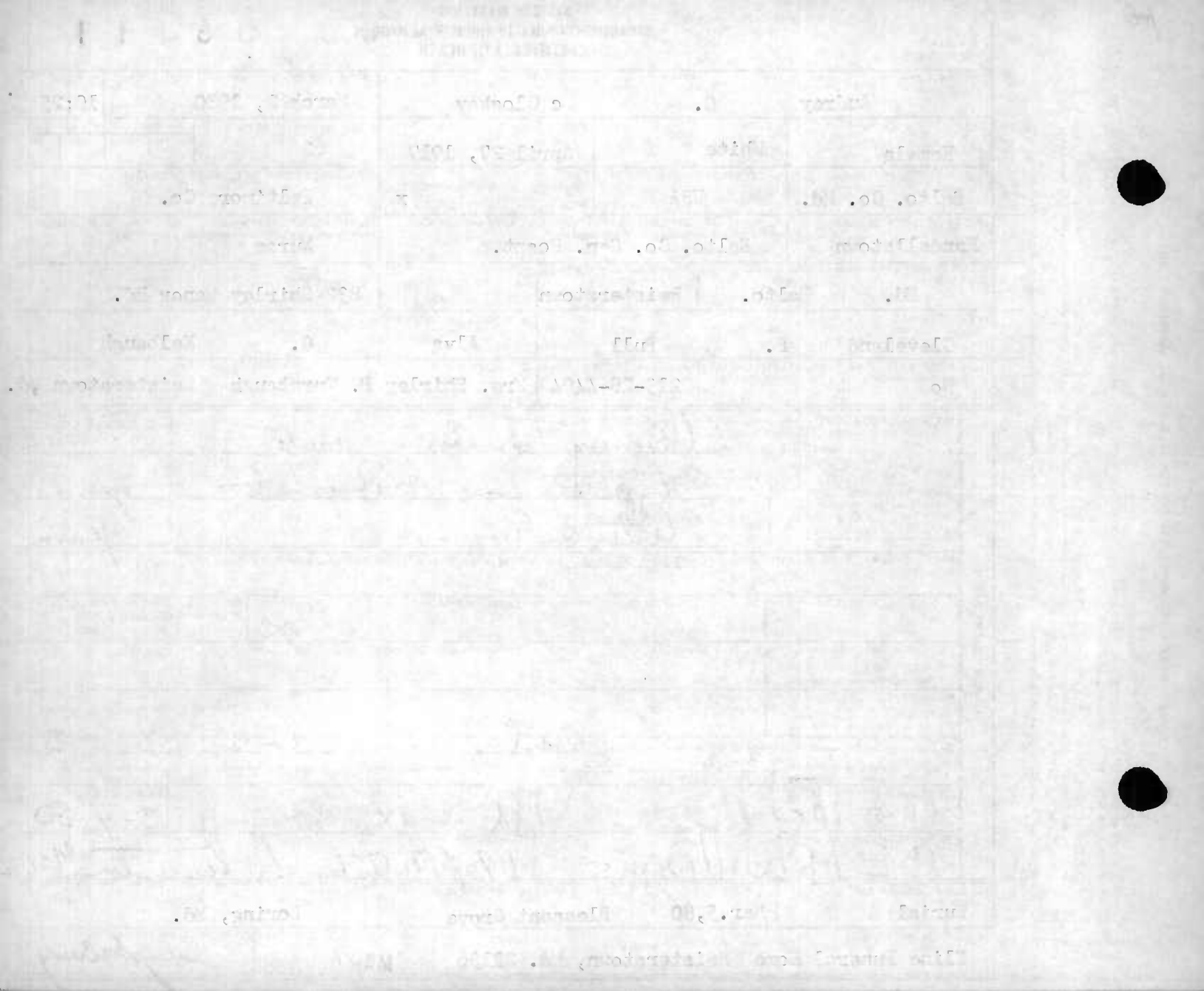
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT! If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 6 1 1 1			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Audrey G. Mc Closkey				March 2, 1980			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 27, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. Co. Gen. Hospt.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY Balto.		13c. CITY OR TOWN Reisterstown	
14. FATHER'S NAME FIRST MIDDLE LAST Cleveland F. Bull				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alva G. Kelbaugh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-28-4404		17. INFORMANT ADDRESS Mrs. Shirley P. Turnbaugh Reisterstown Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - acute</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension malignant</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min. Years Years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 25, 1956, to 3-2-80, that (I) (we) lost the deceased alive on 3-2-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C.E. McWilliams				22c. DEGREE MD		22d. DATE SIGNED 3-4-80	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) C.E. McWilliams				22f. ADDRESS 11904 Reisterstown Rd Reisterstown Md 21136			
23a. BURIAL CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 5, 80		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove		23d. LOCATION CITY OR TOWN COUNTY STATE Boring, Md.	
24. FUNERAL DIRECTOR NAME Eline Funeral Home				25a. DATE REC'D. BY REGISTRAR MAR 6 1980		25b. REGISTRAR'S SIGNATURE P. J. McCreedy	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Madeline Devera McCreer</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>March 28, 1980</i>			2b. HOUR M <i>AM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>April 23, 1897</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>82</i>		7. IF UNDER 1 YEAR MONTHS DAYS <i>0 0</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New Jersey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Randallstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Old Court Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home maker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <i>Md</i>		13b. COUNTY <i>Balto. City</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>5001 Gwynn Oak Ave. 21207</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Josiah Shivers</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>unknown</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <i>---</i>		17. INFORMANT ADDRESS <i>Mrs. Mary Jane Klein 3825 Byfield Rd. 21207</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>436- CVA</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>2 years</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <i>Reisterstown &amp; Slade Ave.</i>		CITY OR TOWN <i>Balto.</i>		COUNTY <i>BALTO.</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>19 78</i> to <i>Mar</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>Dr. Lawrence Solomon</i>				DEGREE <i>MD</i>				22c. DATE SIGNED <i>3/30/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Lawrence Solomon</i>				22e. ADDRESS <i>Reisterstown &amp; Slade Ave.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/31/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Woodlawn</i>		COUNTY <i>BALTO.</i>	
24. FUNERAL DIRECTOR NAME <i>Loring Byers Funeral Directors, P.A.</i>		ADDRESS <i>8728 Liberty Rd Randallstown, Md 21133</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 01 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Jeffrey McCreedy</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

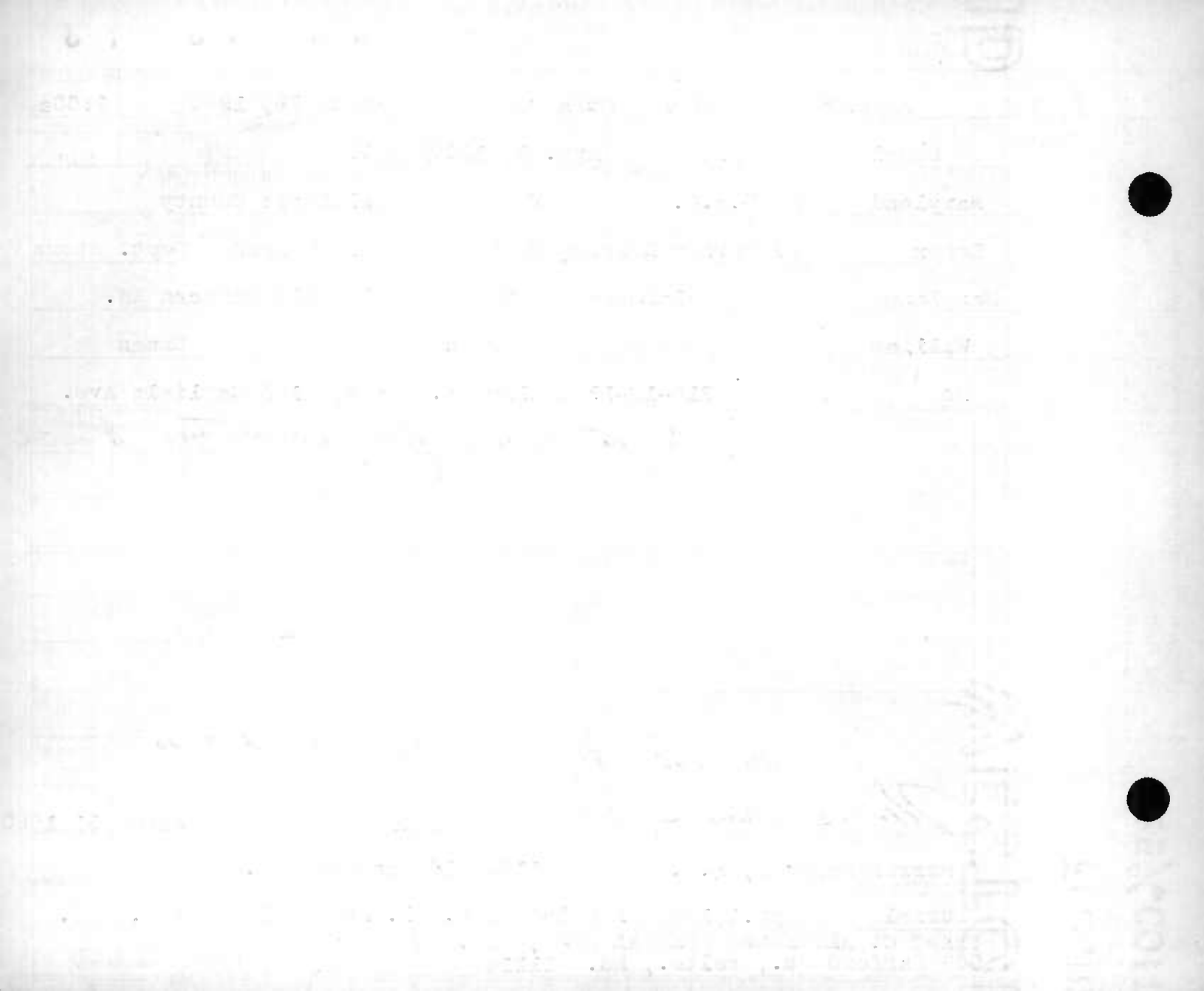
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1- STATE REGISTRAR					REG. NO. 8 0 0 6 1 1 3				
1. DECEASED NAME [TYPE OR PRINT] <b>EMELINE MATILDA McFADDEN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>March 30, 1980</b>			2b. HOUR <b>3:00am</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 3, 1900/</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Essex</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Riverview Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesperson</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. store</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6305 Old Harford Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Perry</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dora Green</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-18-1367</b>		17. INFORMANT ADDRESS <b>Alice E. Adams, 9105 Carlisle Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4280 Congestive heart failure &amp; debilitation</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <b>July 10, 1979</b> to <b>March 30, 1980</b> , that (I) (we) lost saw the deceased alive on <b>March 25, 1980</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE <b>Morris Rainess, M.D.</b> DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>March 31, 1980</b>	
22d. PHYSICIAN'S NAME [TYPE OR PRINT] <b>Morris Rainess, M.D.</b>					22e. ADDRESS <b>1105 Old Eastern Ave.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Apr. 2, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville, Balto., Md.</b>			
24. FUNERAL DIRECTOR <b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b>					25a. DATE REC'D. BY REGISTRAR <b>APR 1 1980</b>		25b. REGISTRAR'S SIGNATURE <i>P. J. Halburdy</i>		
6009 Harford Rd., Balto., Md. 21214									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 0 6 1 1 4		
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Albina D. McHhinney						3 9 1980			10:20 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
Female		White		2 4 1890		90 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		USA				Baltimore County MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Catonsville		Little Sisters of the Poor				Charwoman		Equitable Bldg.				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Maryland			Baltimore			Rosedale			6224 Hamilton Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Joseph Dudeck			Barbara Sedlacek									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS						
no			218-01-0411			James L. McHhinney 6224 Hamilton Avenue						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sudden death - massive</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) <i>M.I. in bathroom. Long standing.</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>A.S. E.O. S.E. H.F. Advanced senility</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 1, 1969</i> to <i>3-9</i> 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>1-31</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Stanley Ankudras</i>			DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>3.10.80</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
STANLEY ANKUDRAS			1101 Maiden Creek La. Baltimore									
23a. BURIAL, CREMATION, REMOVAL			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL			3/14/80		HOLY REDEEMER CEMETERY			BALTIMORE		MD.		
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
HUBBARD FUNERAL HOME 4107 WILKENS AVE. 21229						MAR 14 1980		<i>Harry McCreedy</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Cornelia Ethel MERSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 5, 1980</b>		2b. HOUR <b>2:30<sup>a</sup> M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>02 21 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Johns Hopkins U</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>4205 Cardwell Avenue</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Paul George Michelfelder</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Baumgarten</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO <b>218-40-0440</b>		17. INFORMANT <b>Jeanne Bartenfelter</b>			ADDRESS <b>3013 Edgewood Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from <b>March 4</b> 19 <b>80</b> , to <b>March 5</b> 19 <b>80</b> , that (we) last saw the deceased alive on <b>March 5</b> 19 <b>80</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) view the body after death.								
22b. SIGNATURE <b>Marcia A. Good</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/5/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marcia A. Good</b>				22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/8/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville Baltimore Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Tasaku F.H. 7401 Belair Rd.</b>				25a. DATE BY REGISTRATION <b>MAR 10 1980</b>		25b. REGISTERED SIGNATURE <i>[Signature]</i>		

CONFIDENTIAL



Washington County

County of Washington, D.C.  
In and for the District of Columbia

Ordinaryman's Street

Page 2 of 2

Page 2

CONFIDENTIAL

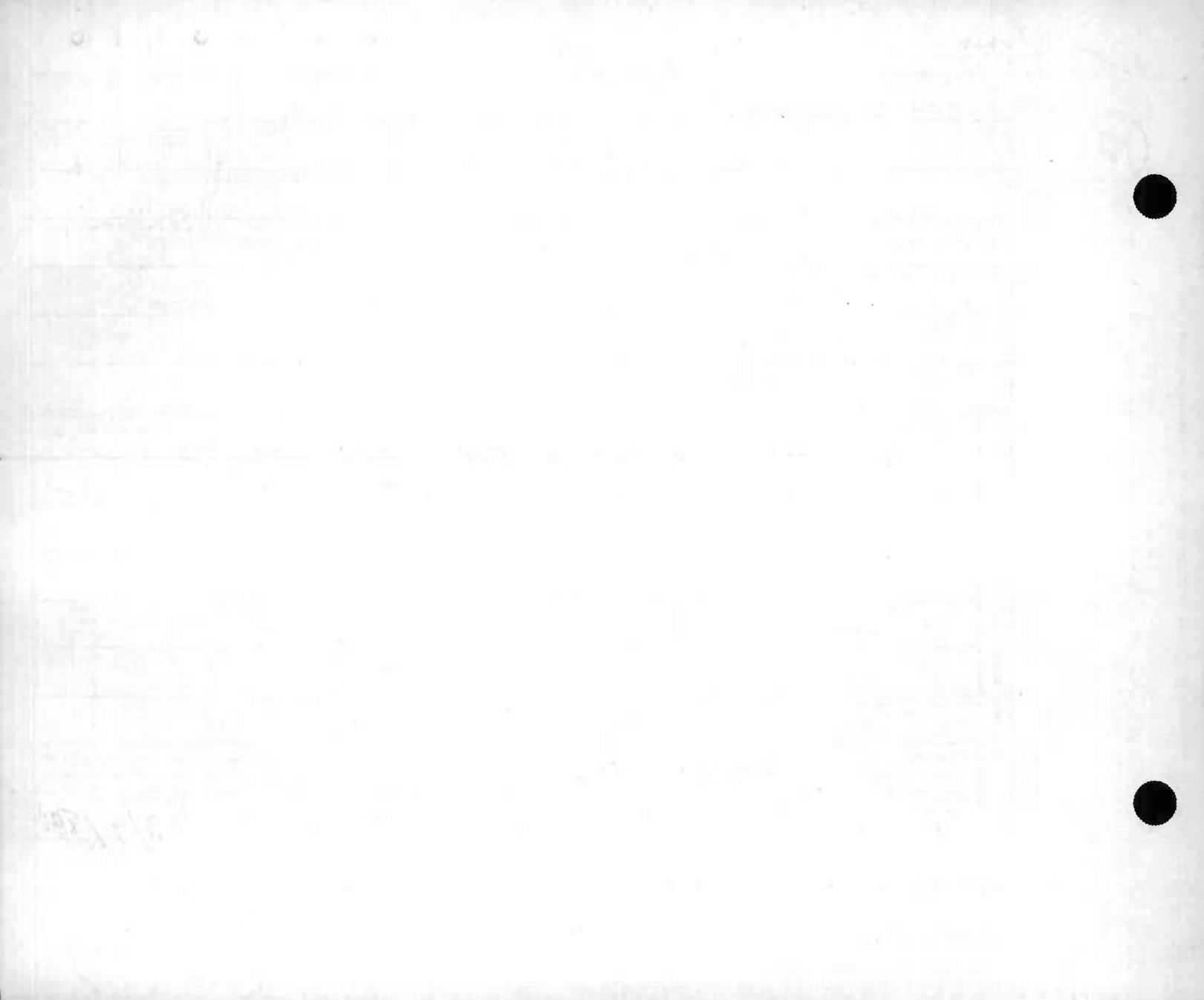
CONFIDENTIAL

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR 1. STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Earl S. Miller, Sr.					2a. DATE OF DEATH MONTH DAY YEAR March 1, 1980			2b. HOUR M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 5, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTH PLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
12. CITY OR TOWN OF DEATH Parkville		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2901 Summit Avenue				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) pipefitter		15. KIND OF BUSINESS OR INDUSTRY		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY Balto.		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William B. Miller					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace E. Lowman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT ADDRESS family records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral failure (post myocardial infarction)</u> 496- DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic pulmonary obstructive disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ascend</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. 3 yrs 2 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>Feb 24</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Edward J. Simon</u>			DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>3/4/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward J. Simon, M.D.			22e. ADDRESS 521 Bourbon St. Havre de Grace							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 3/4/80		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial			23d. LOCATION CITY OR TOWN COUNTY STATE Balto. County, Md.		
24. FUNERAL DIRECTOR NAME Evans Funeral Chapel 8800 Harford Road			25a. DATE REC'D. BY REGISTRAR MAR 10 1980			25b. REAL SIGNATURE				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		XC 11 657 494		REG. NO.		0006117			
1. DECEASED NAME (TYPE OR PRINT) <b>MEYER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 22, 1980</b>				2b. HOUR <b>8:45 A.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCTOBER 12, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> <b>County</b> MD.			
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>V.A. MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MAIL MAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>POST OFFICE</b>	
13a. STATE <b>MARYLAND</b>				13b. CITY OR TOWN <b>BALTIMORE</b>		13c. STREET ADDRESS <b>3617 SPRINGDALE AVENUE</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALEX MILLER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SARAH GOODMAN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>214 24 3322</b>		17. INFORMANT <b>MRS. ELIZABETH MILLER</b> <b>3617 SPRINGDALE AVE. #21216</b> <b>CLINICAL RECORDS, XRAY, XPORT HOWARD, MD, X</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC HEART FAILURE</b> <b>4241</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>AORTIC INSUFFICIENCY</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b> <b>YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CHRONIC BRAIN SYNDROME; PARKINSONS DISEASE - LAST STAGE</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>SEPTEMBER 14, 1977</b> , to <b>MARCH 22, 1980</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>MARCH 22, 1980</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we did) view the body after death.									
22b. SIGNATURE <b>B.K. Yorkoff, MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>3/22/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BENJAMIN K. YORKOFF, M.D.</b>				22e. ADDRESS <b>VAMC, FORT HOWARD, MD</b>					
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>3/23/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ANSHE EMUNAH AITZ CHAIM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MD.</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS</b>				6010 REGISTERSTOWN RD. <b>BALTIMORE, MD. (21215)</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony McReddy</i>	

MEDICAL CERTIFICATION

29

1638 BP

NO. 21 101 00

RECEIVED

1942

APRIL 12 1942

WILLIAM

101

TO THE DIRECTOR, BUREAU OF REVENUE, WASHINGTON, D. C.

FROM THE CHIEF, BUREAU OF REVENUE, WASHINGTON, D. C.

SUBJECT: BUREAU OF REVENUE, WASHINGTON, D. C.

RE: BUREAU OF REVENUE, WASHINGTON, D. C.

DATE: APRIL 12, 1942

BY: [Signature]

FOR THE DIRECTOR, BUREAU OF REVENUE, WASHINGTON, D. C.

BY: [Signature]

RECEIVED BUREAU OF REVENUE - APR 12 1942

101

APRIL 12 1942

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101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

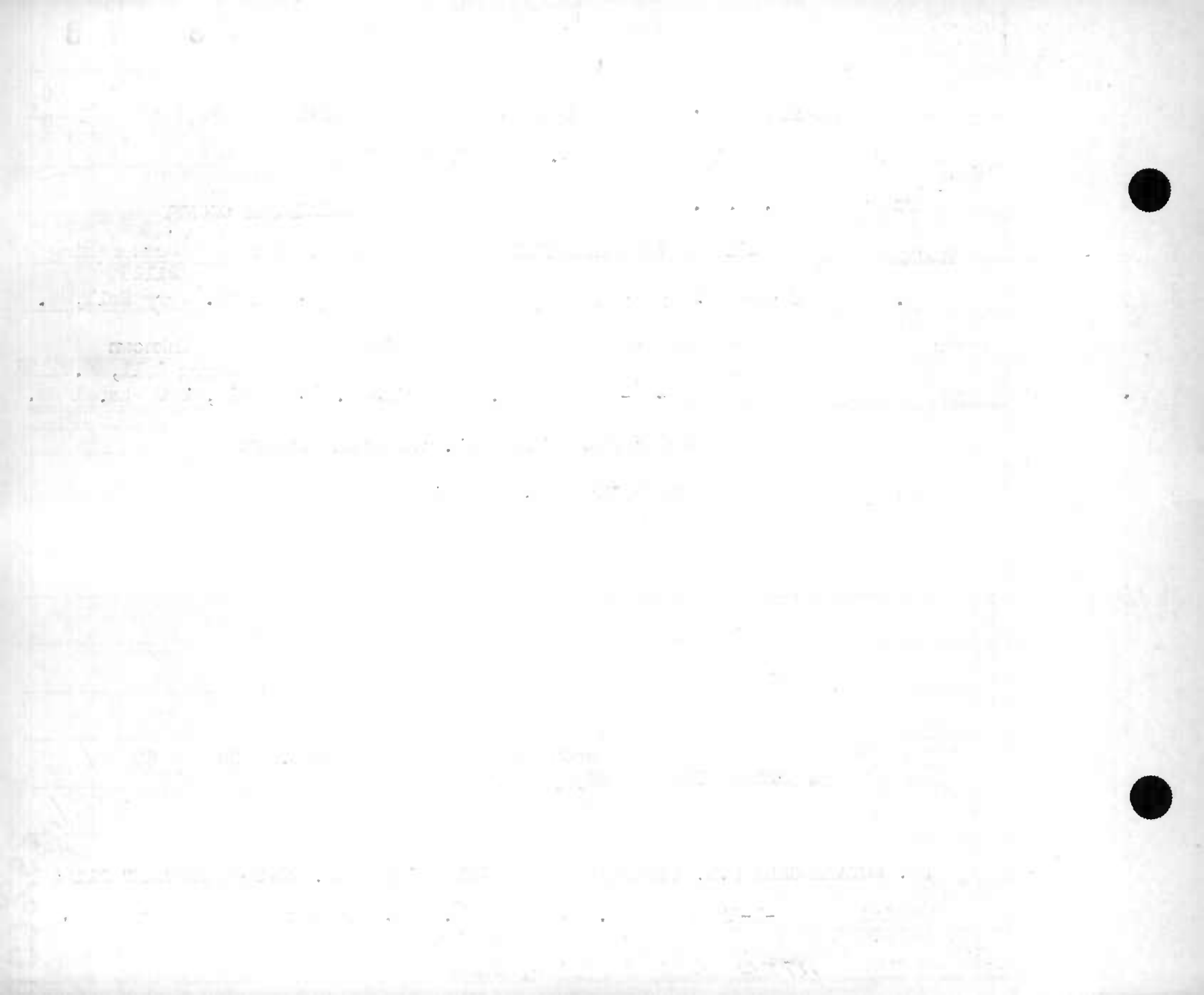
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 0 0 6 1 1 8	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
MARIE H. MIRASSOU						MARCH 30 1980			10 00 AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Female		White		Aug. 30 1888		91 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
France			U. S. A.						BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON			SAINT JOSEPH HOSPITAL			House wife			Home making		
13a. STATE			13b. CITY OR TOWN		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
Md.			Baltimore		Perry Hall		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21128 4260 Chapel Rd. Perry Hall, Md.		
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Basil Lahouratate					Catherine Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS			
no			218-01-8892		Mrs. Catherine L. Oppenheim			Perry Hall, Md. 21128 4260 Chapel Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> <u>4292</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>MARCH 20</u> 19 <u>80</u> to <u>MARCH 30</u> 19 <u>80</u> , that (2) (we) last saw the deceased alive on <u>MARCH 20</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (and) not (we) did not).											
22b. SIGNATURE Vincent Notarangelo					DEGREE		22c. DATE SIGNED				
							ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			3/30/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
DR. NOTARANGELO M.D. (STAFF)					7620 YORK ROAD, TOWSON, MARYLAND 21204						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			4-1-1980		St. Stephens Ch. Cem.			Bradshaw Baltimore Md.			
24. FUNERAL DIRECTOR					DATE REC'D. BY REGISTRAR						
[Signature]					APR 2 1980						
					25b. REGISTRAR'S SIGNATURE						
					[Signature]						

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

Anne Mitchell

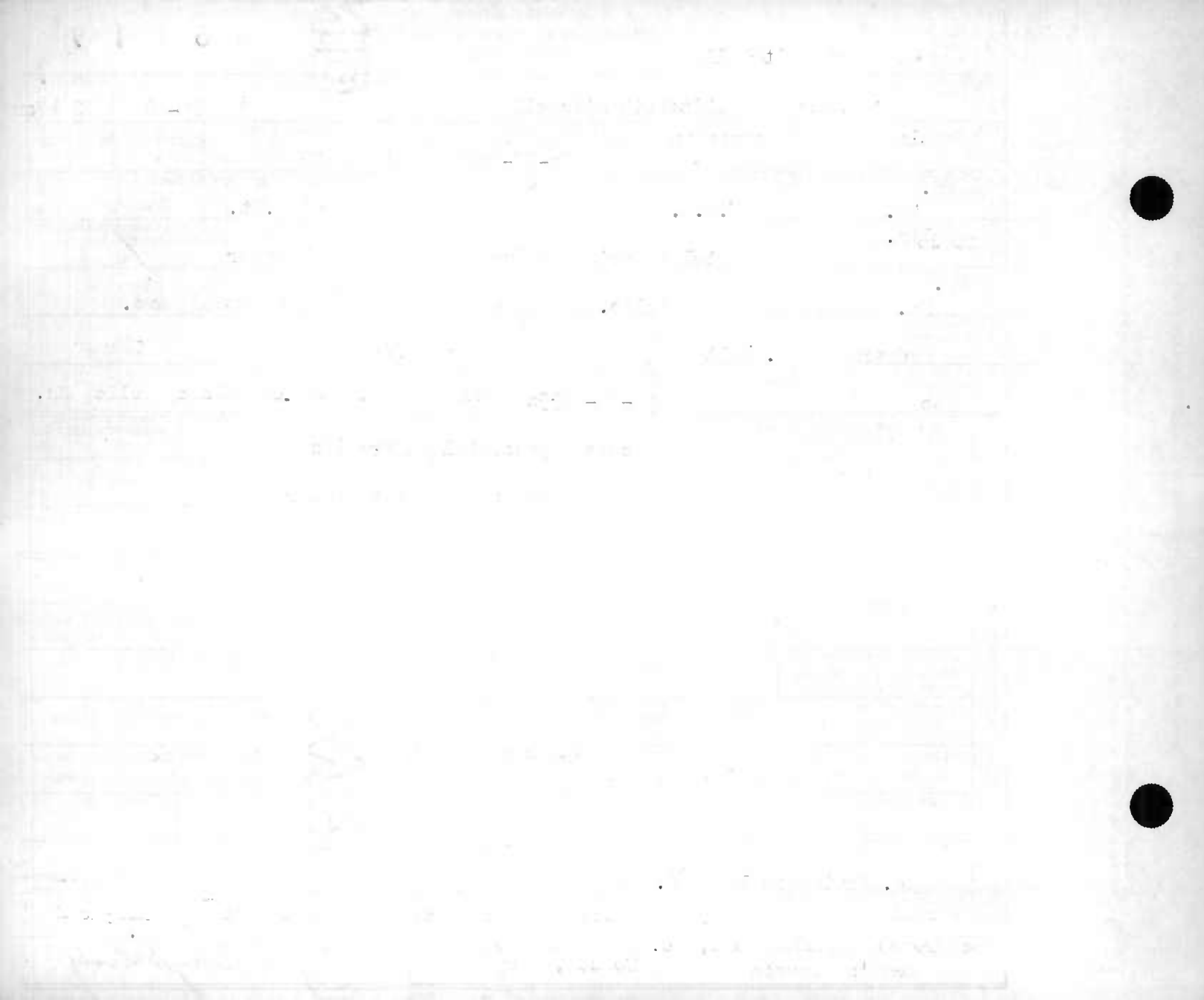
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Anne Elizabeth Mitchell</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3 15-80</b>		2b. HOUR <b>10 47am</b>	
3 SEX <b>female</b>	4 RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10-25-1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. Ct.</b> County <b>MD.</b>	
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Stella Maris Hospice</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>bookkeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Md.</b>		13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward F. Kelly</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Thayer</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>220-14-6338a</b>		17. INFORMANT ADDRESS <b>Stella Maris Hospice Dulaney Valley Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1-28</b> , 19 <b>71</b> , to <b>3-15</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>3-1</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>J. David Nagel</b>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. David Nagel Md.</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-18-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>	
23d. LOCATION CITY OR TOWN COUNTY <b>Baltimore Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>MAR 18 1980</b>			
23f. REGISTRAR'S SIGNATURE <b>Ruck's Towson</b>		23g. REGISTRAR'S SIGNATURE <b>Ruck's Towson</b>			

BP

DHMH-16 20M  
(VRA 15, 4) 7/78

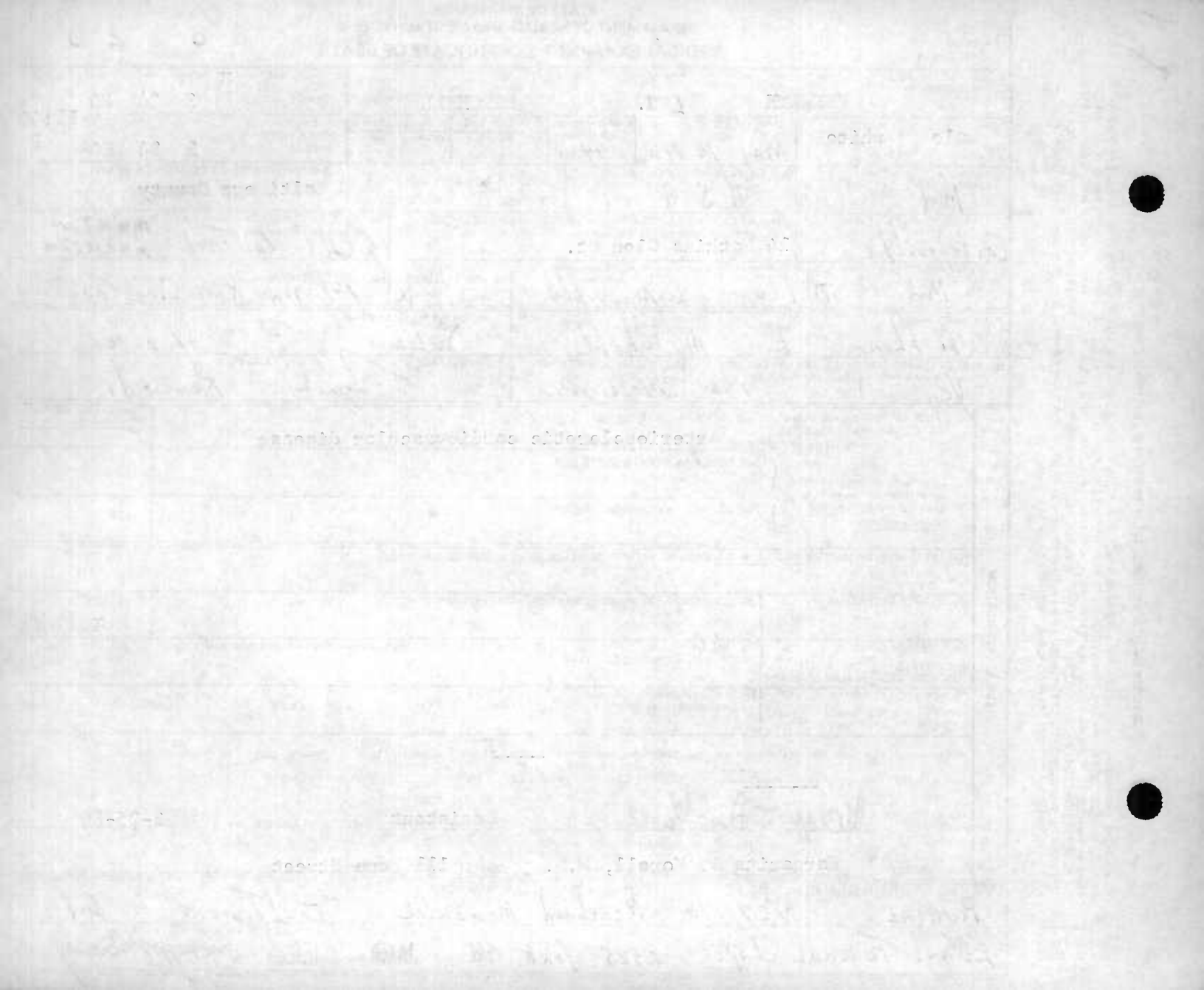


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06120	
1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH						MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
KENNETH		L.		MITCHELL				3 24 1980		11:40 P	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD	
male	white	MAY 16 1930		49 YRS.						3 24 1980	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U. S. A.		WIDOWED		DIVORCED		Baltimore County		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				11a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		11b. KIND OF BUSINESS			
Cockeysville		14 Watkins Glen Ct.				Family Control		MARIETTA			
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. CITY OR TOWN		13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS					
Md. Balto		Cockeysville		YES NO		14 WATKINS Glen COURT					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
William E. Mitchell		Selma P. Webster									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		1950 214-26.3643		Family		Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease											
4292 } DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) } DUE TO, OR AS A CONSEQUENCE OF											
(c) }											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
										YES X NO	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy X, Inspection, Inquiry, and in my opinion death resulted from: Natural causes XX, Accident, Suicide, Homicide, Undetermined manner.											
ACTUAL SIGNATURE		TITLE (SPECIFY)						DATE SIGNED			
Margarita A. Korell		Assistant						3-25-80			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Margarita A. Korell, M.D.		111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
BURIAL		3/27/1980		Moreland Memorial		Baltimore		Md			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
EVANS Funeral Chapel		2325 York Rd		MAR 27 1980							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0006121			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MATILDA F. MOFFET</b>				March 29, 1980			
3. SEX <b>Female</b>				4. RACE <b>White</b>			
5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 28, 1877</b>				6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN <b>102</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Catonsville</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Villa Nursing Home</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dress Fitter</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Retail Store</b>			
13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13b. STREET ADDRESS <b>210 N. Beechwood Ave.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert John Moffet</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Ann Richards</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>				16b. SOCIAL SECURITY NO. <b>217-01-3802</b>			
17. INFORMANT <b>Ellicott City, Md 21043</b> <b>Mrs. H. Mae Grove, 8938 C Town &amp; Country</b>							
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. <b>486- Pneumonia</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Herpes zoster, forehead</b>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (the hospital) attended the deceased from <b>Feb 19 63</b> to <b>3/29 80</b> , that (1) (the) lost the deceased alive on <b>3/29 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If the body was not viewed, so state.)							
22b. SIGNATURE <b>Dr. Christian S. Mass</b>				22c. ADDRESS <b>Howard County Medical Center,</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4/1/80</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Witzke Funeral Home of Catonsville, P.A. 2122</b>				25. DATE REC'D. BY REGISTRAR <b>APR 1 1980</b>			
26. REGISTRAR'S SIGNATURE <b>Christy Kennedy</b>							

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(2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
(HOOKS) ROBERT J. MONROE JR								3 / 24 / 80										8:15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		MONTHS		DAYS		HOURS		MIN.	
M		BLACK		4 / 16 / 08		71													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
MD		USA				MT. WILSON													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
MT. WILSON		THOMAS WILSON CENTER		STEVEDOR - RETIRED															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md.		B		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
ROBERT		ARRENA																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		215-03-2341		Beatrice H. Monroe		2551 McHenry St.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
492-		Pulmonary embolism						6 mo I											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) Carotid arterial Mycobacterial disease																	
		(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		Congestive heart failure.																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (1) this hospital attended the deceased from 9/24, 19 79, to 3/24, 19 80, that (1) was last saw the deceased alive on 3/24, 19 80, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.																			
22b. SIGNATURE		DEGREE		22c. DATE SIGNED															
ET. Sutton-Soliman, MD				3/24/80															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
ELLA I. SUTTON-SOLIMAN, MD		THOMAS WILSON CENTER																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial		3/29/80		Mt. Auburn Cem.		Baltimore MD													
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
Wm. C. March F/H 1101 E. North Ave.		MAR 27 1980		Rifney McCreedy															

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

0 6 1 2 3

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Edward James Moore</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 13, 1980</b>			2b. HOUR <b>01:29</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7-1-25</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>California</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SAINT JOSEPH HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Contractor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>313 Taplow Rd 21212</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward James Moore</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Louise Vessels</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT <b>Mary Ann Moore</b>		ADDRESS <b>313 Taplow Rd 21212</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>410 -</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Blocked</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>WAS</b> <b>YRS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 22</b> , 19 <b>80</b> , to <b>March 13</b> , 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>March 13</b> , 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.									
22b. SIGNATURE <b>Richard Biggs</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>13/3/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard Biggs, M.D.</b>						22e. ADDRESS <b>7401 Osler Dr., Room 212, Baltimore, MD 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-15-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Mary's</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore --- Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home</b>						ADDRESS <b>6500 York Rd 21212</b>		25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>MAR 18 1980</b> <b>Henry McCurdy</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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Items 18a22a G544 6/6/80 dad

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 06124

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Pamela		Ann		Moore				XX		3		20		1980				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Female	White	5 11 52		27 YRS.						3		20		1980				6:40 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
Md.		USA		WIDOWED		DIVORCED		Baltimore County,										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Timonium		70 Cinder Rd.		Waitress		Food													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md.		Balto.		Timonium		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		70 Cinder Rd., Timonium											
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST									
Harley		Stanley		Moore		Nettie		Dolores		Gwin									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		219-58-4031		Mrs. Plantholt, 70 Cinder Rd.		21093													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) <u>Seizure Disorder</u>																			
7803																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
								STREET CITY OR TOWN COUNTY STATE											
22. I certify that I took charge of the remains described above, held on death resulted from <input checked="" type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion																			
TITLE (SPECIFY)																			
Deputy Chief																			
DATE SIGNED 3/20/80																			
ACTUAL SIGNATURE <u>Thomas D. Smith</u> M.D. Deputy Chief MEDICAL EXAMINER																			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. ADDRESS 111 Penn St. Balto., MD.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				3/22/80				Dulaney Valley Cem.				Cockeysville, Md.							
24. FUNERAL DIRECTOR'S NAME (TYPE OR PRINT) J. E. Lowell Lemmon, 10 W. Padonia Rd. ADDRESS																			
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE																			
MAR 24 1980 <u>Patricia M. Brady</u>																			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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MAR 14 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

FOR 1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 06125			
1. DECEASED NAME (TYPE OR PRINT) <b>VIRGINIA H. MOORE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3-12-80</b>				2b. HOUR <b>2:46</b> AM			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 14, 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Balto. County Gen. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Harkel Inc. Contractor</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13b. STREET ADDRESS <b>7023 Brompton Road 21207</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Woodmoore</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Earl Green</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Schultz</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-22-9658</b>		17. INFORMANT <b>Mr. E. Glenn Moore</b> <b>7023 Brompton Road Balto. MD. 21207</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral hemorrhage</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STOLEN THE UNDERLYING CAUSE LAST: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>one month</b> <b>years</b> <b>years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Acute bronchopneumonia, both lungs.</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2-13-80</b> to <b>3-12-80</b> , that (I) (we) lost saw the deceased alive on <b>3-12-80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) pay the body after death											
22b. SIGNATURE <b>Somchal Hong</b>				DEGREE <b>Pathologist</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>3-12-80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SOON CHUL HONG</b>				22e. ADDRESS <b>Baltimore County General Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>3/13/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto. Maryland</b>			
24. FUNERAL DIRECTOR <b>Loring Byers Funeral Directors, P.A.</b> NAME ADDRESS <b>8728 Liberty Road Randallstown, MD. 21133</b>											
DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE <b>Loring McCreedy</b>					

BP

MOORE

W. C. MOORE

W. C. MOORE, JR.

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W. C. MOORE, JR.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06126	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		2b. HOUR	
		Lloyd Franklin Moreland				3 23 19 80		3 23 19 80		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR		IF UNDER 24 HRS	
Male		White		Oct. 13, 1936		43 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		12b. HOUR	
West Virginia		USA		WIDOWED		DIVORCED		Baltimore County, MD		11:10 P M	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Essex		918 N. Marlyn Avenue		Brakeman		B&O Railroad					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Baltimore		Essex		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		918 N. Marlyn Ave. 21221			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		16a. No		236 48 0058		Frances B. Moreland, Wife		Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
9550		Gunshot Wound of Head (handgun)									
				(b)		DUE TO, OR AS A CONSEQUENCE OF					
				(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		? P.M. 3 23 19 80		Subject shot self							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		home		918 N. Marlyn Ave.,		Essex		Baltimore		Md.	
22a. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from:		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
Virginia L. Dolan		Assistant		3/24/80							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Virginia L. Dolan, M.D.		111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
Burial		3/28/80		Holly Hill Memorial Gardens		Baltimore		Essex		Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Brazdzinski Funeral Home		MAR 26 1980		Brazdzinski							
1407 Old Eastern Ave.											





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>EDITH V. MORRIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-28-80</b>			2b. HOUR <b>10</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 4 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Freeland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mt. Zion Rd.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Coun Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Freeland</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Mt. Zion Road</b>	
14. FATHER'S NAME FIRST <b>Henry</b> MIDDLE <b>W.</b> LAST <b>Simpson</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Julia</b> MIDDLE <b>Rasier</b> LAST <b>Rasier</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>230-345819</b>		17. INFORMANT <b>Ernest A. Morris</b> ADDRESS <b>Mt. Zion Road, Freeland, Md. 21053</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY.

**4140** IMMEDIATE CAUSE (a) **C. S. H. D.**  
DUE TO, OR AS A CONSEQUENCE OF (b) \_\_\_\_\_  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1967</b> to <b>3/27</b> <b>1980</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>3/26</b> <b>1980</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death.							
22b. SIGNATURE <b>A. M. France</b> MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3/29/80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. M. FRANCE</b>				22e. ADDRESS <b>Freeland Md 21030</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>March 30, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Freeland Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME <b>James Hartenstein</b> ADDRESS <b>New Freedom, Pa.</b>				25. DATE DEC'D. 1980 REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

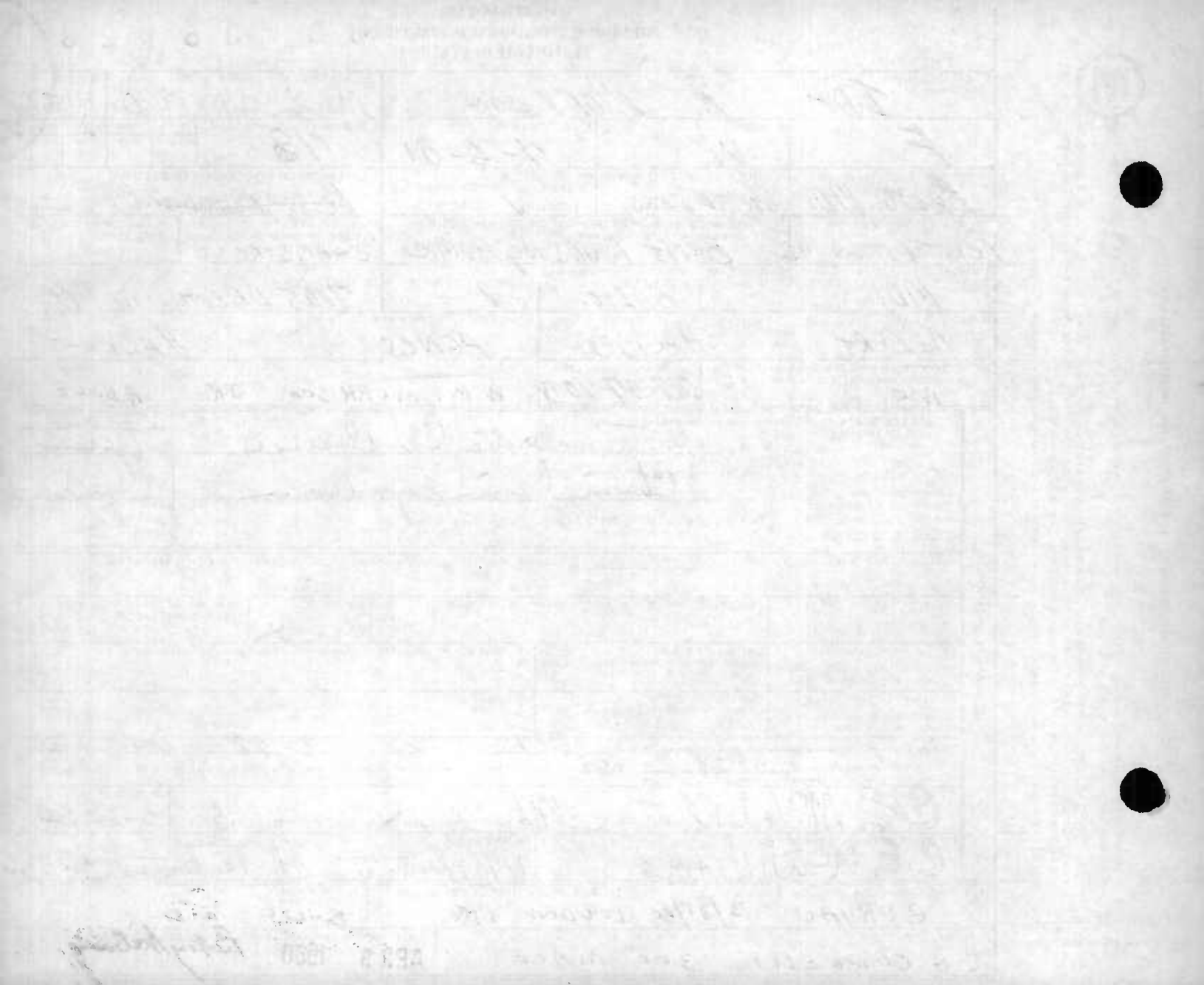
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 006128									
1. DECEASED NAME (TYPE OR PRINT)		FIRST IDA		MIDDLE P.		LAST MORRISON		2. DATE OF DEATH MONTH DAY YEAR March 28, 1980		2b. HOUR 11:50 AM	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 7-6-01		6. AGE (IN YEARS LAST BIRTHDAY) 79		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. Reisterstown County, MD.					
10. CITY OR TOWN OF DEATH Reisterstown, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BENT Nursing Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7005 Brentwood Ave			
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT HECKLER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES HACKETT									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-077018		17. INFORMANT ADDRESS W.M. MORRISON JR. ABOVE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Atherosclerosis CV Disease DUE TO, OR AS A CONSEQUENCE OF (b) Chronic brain syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 1-14, 1980, to 3-28, 1980, that (I) (we) lost saw the deceased alive on 3-28, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C.E. McWilliams		22c. DATE SIGNED 3-28-80		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) C.E. McWilliams		22f. ADDRESS 11904 Reisterstown Rd Reisterstown MD 21136									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/31/80		23c. NAME OF CEMETERY OR CREMATORY LEWODON PK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD					
24. FUNERAL DIRECTOR NAME J.G. CONNELLY		ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR APR 3 1980		25b. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION

2

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										06129 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Wincenta M. Mozejko</i>										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <i>March 23 1980</i>										2b. HOUR MIN <i>5P</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Nov 24 1895</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>84</i>		IF UNDER 1 YR. MONTHS DAYS <i></i>		IF UNDER 24 HRS. HOURS MIN. <i></i>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>March 23 1980</i>										2d. HOUR MIN <i>5P</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Poland</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i>										MD	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Josephs Hospital</i>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE <i>MD.</i>				13b. COUNTY				13c. CITY OR TOWN <i>Balto</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS <i>6000 Belona Avenue</i>							
14. FATHER'S NAME FIRST MIDDLE LAST <i>Benedict Benecewicz</i>								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Agatha Unknown</i>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>216-03-0741</i>				17. INFORMANT <i>Jessica Taylor</i>				ADDRESS <i>10501 Adel Road Oakton, Virginia</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Fracture of Pelvis, Rt Hip &amp; Rt Humerus</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized ASCVD</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 Hrs</i> <i>2 Days</i> <i>10±%</i>																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. March 21 1980</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Fell in Room in Nursing Home</i>															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Nursing Home</i>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>6000 Belona Ave Balto City Md</i>															
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <i>Charles F. O'D</i>				TITLE (SPECIFY) <i>Deputy</i>				MEDICAL EXAMINER				DATE SIGNED <i>3/23/80</i>											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>3-26-80</i>				23c. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus Cem</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>											
24. FUNERAL DIRECTOR NAME ADDRESS <i>John M. Weber &amp; Sons Inc. 401 S. Chester St.</i>										25a. DATE REC'D. BY REGISTRAR <i>MAR 26 1980</i>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

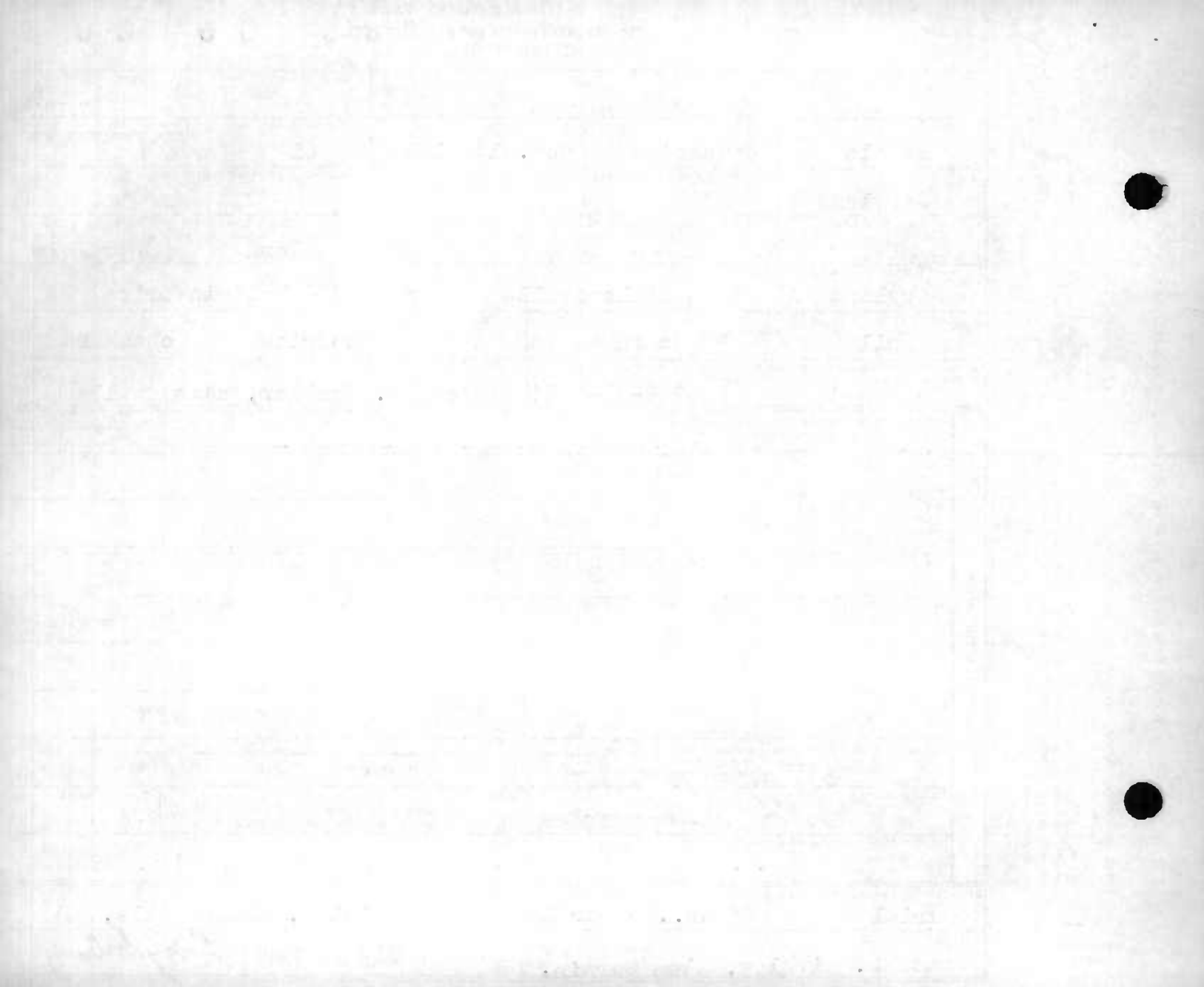


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 06130							
1 DECEASED NAME (TYPE OR PRINT) Dorothy Mueller					2a DATE OF DEATH 3/20/80			2b HOUR 7:18A M	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH Oct. 14 1918		6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b KIND OF BUSINESS OR INDUSTRY Drug Fair	
13a STATE Maryland		13b COUNTY AA		13c CITY OR TOWN Millersville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 1726 Baldwin Drive	
14 FATHER'S NAME Emil Schanken					15 MOTHER'S MAIDEN NAME Ada Goodrich Schanken				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 218-01-9374		17 INFORMANT ADDRESS Joseph F. Mueller, same as 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Breast</u> 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/19/80</u> , 19_____, to <u>3/20/80</u> , 19_____, that (I) (we) lost saw the deceased alive on <u>3/20/80</u> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>S. Shafik</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/20/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Shafik, M.D.				22e. ADDRESS GBMC, 6701 N. Charles St. Balto. 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 24Mar..80		23c. NAME OF CEMETERY OR CREMATORY Our Lady of the Fields		23d. LOCATION CITY OR TOWN, COUNTY, STATE Millersville, AA MD			
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD				ADDRESS		25a. DATE REC'D. BY REGISTRAR MAR 21 1980		25b. REGISTRAR'S SIGNATURE <i>History McCreedy</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO. 8 0 0 6 1 3 1							
1. DECEASED NAME (TYPE OR PRINT) <b>ELSIE M. MULLEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 19 80</b>			2b. HOUR <b>11-10 A M</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 1, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>11-10 A M</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Lynchburg, Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. Co.</b> MD				
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Balto. Co. Gen. Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Store Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6047 Cecil Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur Martin</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary ?</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT <b>6047 Cecil Ave. Balto. Md. 21207</b> <b>Mr. Lawrence Mullen</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-vascular arrest</b> <b>496-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>End stage COPD atelectasis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cirrhosis</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>2-28-1980</b> , to <b>3-19-1980</b> ; that (I) (we) last saw the deceased alive on <b>3-19-1980</b> ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>R-m. Shah</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>3-19-80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R-m. SHAH M.D.</b>				22e. ADDRESS <b>B.C.G.-H.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-21-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>G. Truman Schwab</b>				ADDRESS <b>5151 Balto. National Pike Balto. Md. 21229</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 26 1980</b>		25b. REGISTRAR'S SIGNATURE <b>notary McCreedy</b>		

1. Thomas Schwebel 5151 Balto. National Pike  
 Balto. Md. 21228  
 Burial 3-31-1980 Woodlawn Cem. Woodlawn Balto. Md.

no Arthur Md. Balto. Catonsville  
 6047 Cecil Ave. Balto. Md. 21207  
 Mr. Lawrence Eulien

Md. Balto. Catonsville  
 6047 Cecil Ave. x  
 Stone Corner Balto. Md. 21207

Landallstown Balto. Co. Gen. Hosp.  
 U.S.A. Balto. Co.

Female White June 1, 1924 35

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Milburn Irvin Mullineaux			2a DATE OF DEATH MONTH DAY YEAR March 18, 1980			2b HOUR 3A.M.					
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR November 9, 1887		6 AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10 CITY OR TOWN OF DEATH Woodlawn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6908 Dogwood Road, Balto. 21207				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant		12b KIND OF BUSINESS OR INDUSTRY Self Emp.			
13a STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Woodlawn		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 6908 Dogwood Road			
14 FATHER'S NAME FIRST MIDDLE LAST Richard Mullineaux				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa Loos							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17 INFORMANT ADDRESS Marie Mullineaux 6908 Dogwood Road					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) C. V. A. 436- DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) Chronic congestive heart failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Days 15 years 2 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death. March 17, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
22b SIGNATURE Edwin L. Pierpont, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 3/18/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Edwin L. Pierpont, M.D.						22e ADDRESS 8204 Liberty Road 21207					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 3/20/80		23c NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery			23d LOCATION CITY OR TOWN COUNTY STATE Randallstown, Balto Co. Md.			
24 FUNERAL DIRECTOR 8728 Liberty Road Randallstown, Maryland						25a DATE REC'D. BY REGISTRAR MAR 19 1980		25b REGISTRAR'S SIGNATURE			

10/10/1919  
10/10/1919

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

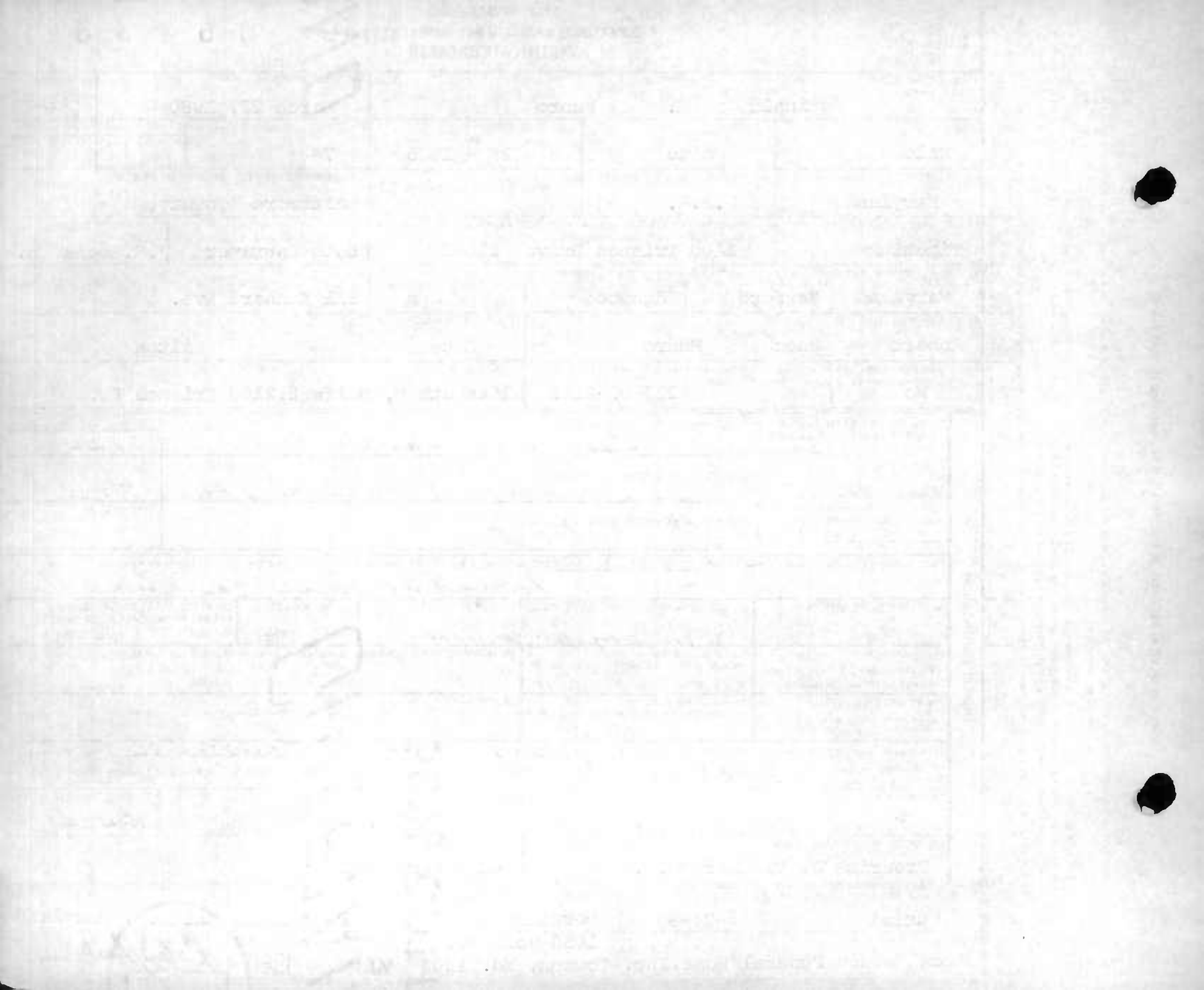
FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Reginald W. Munro</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 22, 1980</b>		2b. HOUR <b>7A</b> M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 - 29 - 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Timonium</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2100 Trianos Drive 21093</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Photo Engraver</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>A.S. Abell Co.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY 13c. CITY OR TOWN <b>Maryland Harford Edgewood</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>311 Kennard Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Enoch Munro</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kate Walton</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-03-2285</b>		17. INFORMANT ADDRESS <b>Elizabeth M. Seifert, 2100 Trianos Dr.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of skin</b> <b>1739</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Squamous cell carcinoma, skin</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yr</b> <b>7 yr</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Hodgkins disease radiated</b>					
19a. DATE OF OPERATION <b>Apr '78</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Squamous cell carcinoma</b>		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>May 1948</b> , to <b>Nov 82</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>Mar 21</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Fredrick J. Vollmer, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>Mar 24, 80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Fredrick J. Vollmer, M.D.</b>		22e. ADDRESS <b>6100 York Road</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3-24-80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moreland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville, Balto., Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Dorothy M. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
DEATH									
REG. NO. 06134									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ernette Murdock</b>									
2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.	
Female		Black		7 7 1957		22 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		DIVORCED	
Maryland		USA		WIDOWED		NEVER MARRIED		DIVORCED	
9. BALTIMORE CITY OR COUNTY OF DEATH		Baltimore County, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Owings Mills		Rosewood Center							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5517 Robinwood Road	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Erneat Murdock				Mary White					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No						Mary V. Hauls 5517 Robinwood Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I DEATH WAS CAUSED BY: <b>Diffuse encephalopathy, cause not determined</b>									
IMMEDIATE CAUSE (a) <b>Postencephalytic Cerebral Atrophy</b>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>				TITLE (SPECIFY) <u>Assistant</u>		MEDICAL EXAMINER		DATE SIGNED <u>3/23/80</u>	
EXAMINER'S NAME (TYPE OR PRINT) <u>Virginia L. Dolan, M.D.</u>				ADDRESS <u>111 Penn Street</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		3 27 1980		Cedar Hill Cem		A.A. CO. Md.			
24. FUNERAL DIRECTOR NAME <u>Isaiah L. Brown &amp; Son</u>				ADDRESS <u>PA 1913 W. Balto.</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 28 1980</u>		25b. REGISTRAR'S SIGNATURE <u>Isaiah L. Brown</u>	



CO. 10 2

Section

Station

General Remarks

Local Notes

Remarks

Observations on the weather



Sketch of the land



CO. 10 2

Section

Station

General Remarks

Local Notes

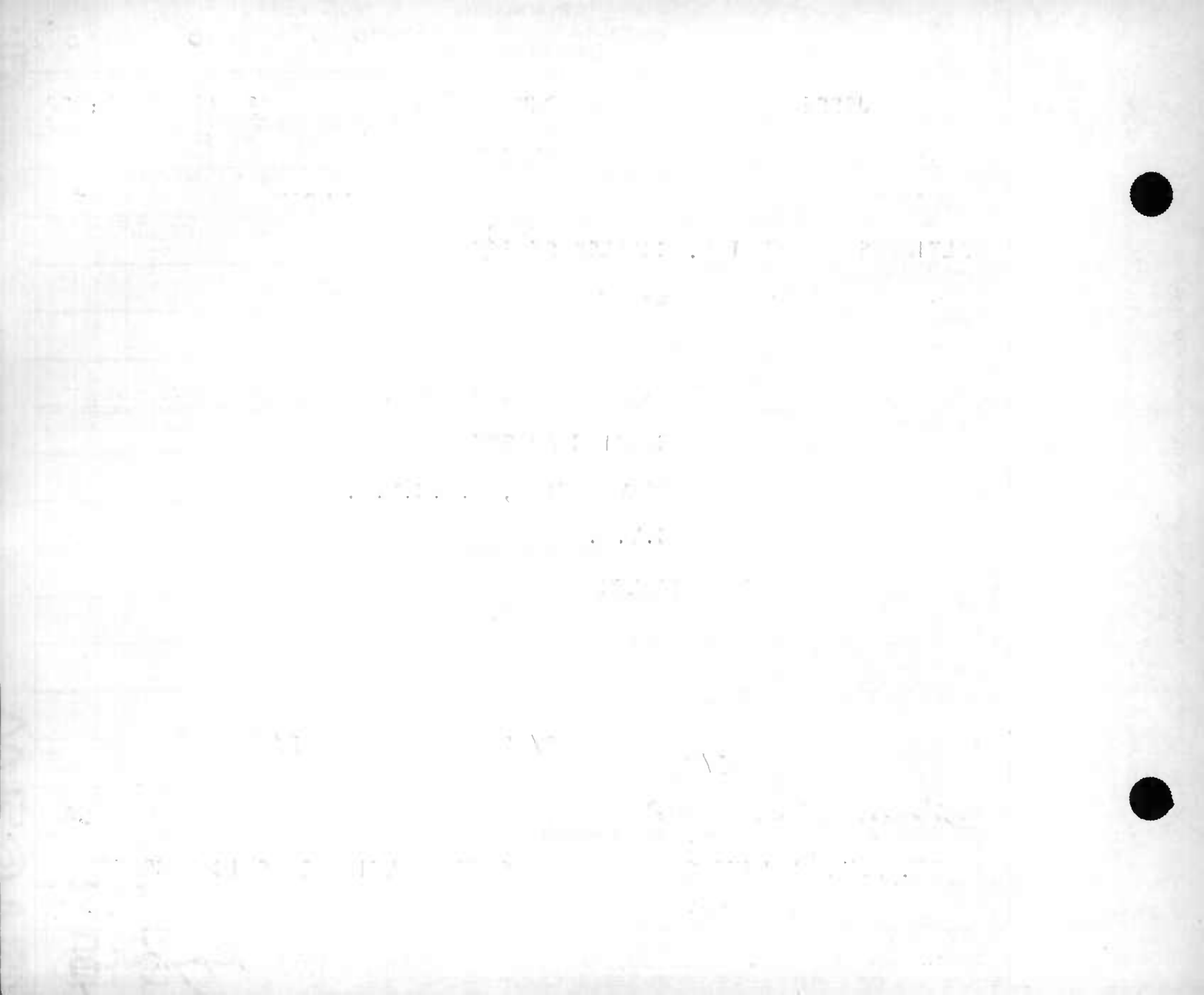
Remarks

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

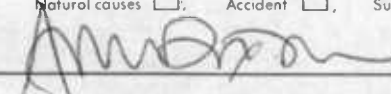
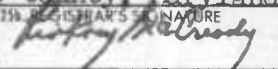
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7006135			
1. FOR STATE REGISTRAR		REG. NO.											
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR
JESSE		E.		MURPHY				03		07	80	7:02P <sub>M</sub>	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		April 1, 1898		81		MONTHS		DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				TOWSON						MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY							
BALTIMORE		6701 N. CHARLES STREET		Electrical Contractor									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Md.		Baltimore		Perry Hall		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		9917 Marilyn Road					
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
Murphy													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS							
yes		WW 1 & 2		215-32-7798		Mr. Robert E. Murphy		9917 Marilyn Road					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) CARDIAC ARREST													
436- DEHYDRATION, A.S.C.V.D.													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF													
C.V.A.													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
POOR HEALTH													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION		CITY OR TOWN		COUNTY		STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>													
22a I certify that (I) (this hospital) attended the deceased from 03/02 19 80 to 03/07 19 80, that (I) (we) lost saw the deceased alive on 03/07 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE		DEGREE		22c DATE SIGNED									
DR. ANTHONY VETERE				3-7-80									
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS											
DR. ANTHONY VETERE		GREATER BALTIMORE MEDICAL CENTER											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		Mar. 11. 1980		Parkwood		Baltimore				Md.			
24 FUNERAL DIRECTOR		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE									
NAME		ADDRESS											
Leonard J. Ruck Inc. Baltimore, Maryland		MAR 11 1980											



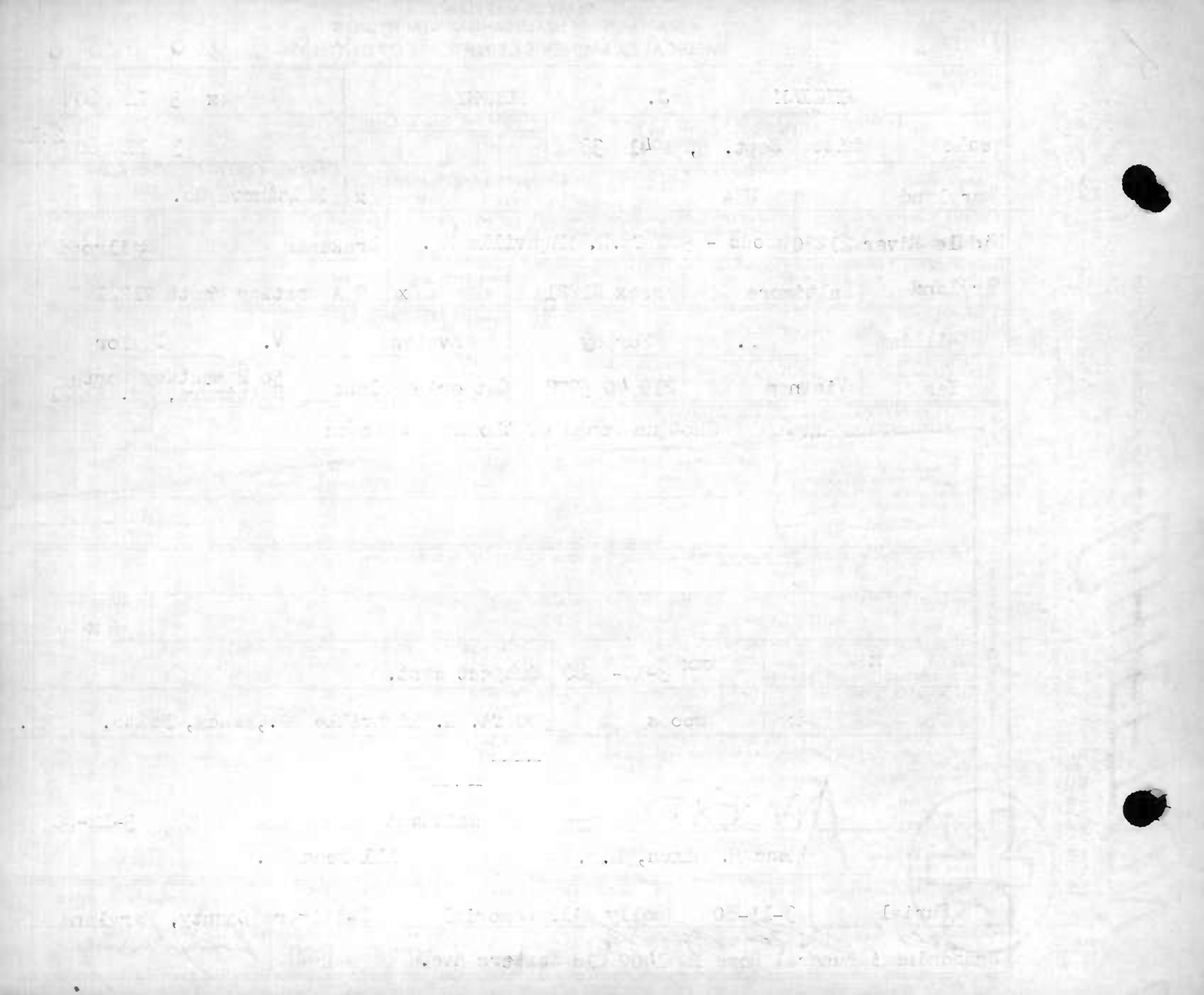
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5-FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS-301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M/7/77

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06136			
1. DECEASED NAME (TYPE OR PRINT) WILLIAM J. MURPHY										2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 3 10 19 80										2b. HOUR M			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Sept. 8, 1941		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 3 11 19 80										2d. HOUR M 2:10 P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD											
10. CITY OR TOWN OF DEATH Middle River 21220				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Woods - 900 ft. N. Highville Rd.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brakeman				12b. KIND OF BUSINESS OR INDUSTRY Railroad							
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Essex 21221		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9 A Westway South 21221													
14. FATHER'S NAME FIRST MIDDLE LAST William P. Murphy										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn V. Taylor													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. Vietnam		17. INFORMANT Catherine Blake				ADDRESS 50 B Westway North Baltimore, Md. 21221													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Shotgun wound of thorax & abdomen IMMEDIATE CAUSE (a) 9651 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM MONTH DAY YEAR P.M. 3-10- 1980				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot.															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) woods				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 900 ft. N. Highville Rd., Essex, Balto. Md.															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 3-12-80									
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St.																			
23a. BURIAL, CREMATION, REMOVAL (TYPE OF) Burial				23b. DATE 3-15-80		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Maryland													
24. FUNERAL DIRECTOR NAME Brudzinski Funeral Home				25a. DATE REC'D. BY REGISTRAR MAR 13 1980				25b. REGISTRAR'S SIGNATURE 															

4507





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) AKA FIRST Fred H. Musser FREDERICK H. MUSSER		2a. DATE OF DEATH MONTH DAY YEAR March 23, 1980		2b. HOUR 2:45p M	
3 SEX Male	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR July 18, 1900	6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH Rossville 21237	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steel Molder	12b. KIND OF BUSINESS OR INDUSTRY Beth.Steel	
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Essex 21221	13d. STREET ADDRESS 1604 Rickenbacker Road 21221	
14 FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 188-07-0811	17 INFORMANT ADDRESS Fred Musser, Son 100 Kent Road Glen Burnie, Md. 21061			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Lower Lobe Pneumonia</u> <u>complicating Arteriosclerotic Cardio-vascular &amp; Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 12</u> , 19 <u>80</u> , to <u>March 23</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 23</u> , 19 <u>80</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward Suarez		DEGREE		22c. DATE SIGNED 3-23-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward Suarez		22e. ADDRESS 9000 Franklin Square Drive W21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-25-80	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24 FUNERAL DIRECTOR Brodzinski Funeral Home PA 1407 Old Eastern Ave.		25a. DATE REC'D. BY REGISTRAR MAR 26 1980		25b. REGISTRAR'S SIGNATURE Dorothy McCreedy	

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

1506 1507 1508 1509

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05-5-1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) <b>PAUL M. MYERBERG</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>March 9, 1980</b>	
3 SEX <b>MALE</b>		2b. HOUR <b>9A</b> M	
4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 24, 1916</b>	
6 AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	
8. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN <b>RANDALLSTOWN MARYLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSPITAL</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CONSULTANT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>LIFE INSURANCE</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>BALTO.</b>	
13c. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>812 HOPEWOOD RD. #21208</b>	
14 FATHER'S NAME <b>PHILLIP</b> MIDDLE <b>NATHAN</b>		15 MOTHER'S MAIDEN NAME <b>REBECCA</b> MIDDLE <b>KIRSCHENBAUM</b> LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO <b>213-10-6452</b>	
17 INFORMANT <b>MRS. LENORA MYERBERG</b> ADDRESS <b>812 HOPEWOOD RD. BALTO. MD 21208</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <b>Post cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Diabetes mellitus</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.	
21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 2, 1980</b> to <b>March 9, 1980</b> , that (I) (we) lost saw the deceased alive on <b>March 9, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Ghassem Pourmotabbed, M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22c. DATE SIGNED <b>March 9, 1980</b>			
23a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GHASSEM POURMOTABBED</b>		23b. ADDRESS <b>Balto. County Gen. Hospital</b>	
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23d. DATE <b>MAR. 10, 1980</b>	
23e. NAME OF CEMETERY OR CREMATORY <b>BETH EL MEM. PARK</b>		23f. LOCATION CITY OR TOWN COUNTY STATE <b>RANDALLSTOWN BALTO. MD</b>	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS <b>6010 REISTERSTOWN RD. BALT., MD 21215</b>		25. DATE REC'D. BY REGISTRAR <b>MAR 11 1980</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Michael Nardone</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 9 1980</b>			2b. HOUR <b>4:38 PM</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 17 21</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>News American</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Vito Nardone</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria Stekla Fusca</b>			16. STREET ADDRESS <b>1102 Bethelhem Avenue</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>WW 2</b>		17. INFORMANT NAME ADDRESS <b>Gloria Herman 1102 Bethelhem Avenue</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>410 -</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIO SCLEROTIC CARDIO-VASC. DS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 yrs.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8/4 19 62</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3/4 19 80</b>		21g. I certify that (I) (this hospital) attended the deceased from <b>3/11/80</b> to <b>3/9 19 80</b> , that (I) (we) lost saw the deceased alive on <b>3/11/80</b> above, (I) (we) (did not) view the body after death.		
22a. SIGNATURE <b>Steven B Kaplan MD</b>			22b. DEGREE <b>MD</b>			22c. DATE SIGNED <b>3/11/80</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Steven B Kaplan, M.D.</b>	
22e. ADDRESS <b>9000 Franklin Square Dr., 21237</b>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/12/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md</b>			24. FUNERAL DIRECTOR NAME ADDRESS <b>Walter Dabrowski 1005 Dundalk Avenue</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Patrick McCreedy</b>	

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## Analysis

Baltimore

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Memorial

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO. 006140			
1. FOR STATE REGISTRAR				2. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Lois Rowe Neff</i>				2. DATE OF DEATH MONTH DAY YEAR <i>March 16, 1980</i>			
3. SEX <i>Female</i>				4. RACE <i>White</i>			
5. DATE OF BIRTH MONTH DAY YEAR <i>February 5, 1897</i>				6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i>			
10. CITY OR TOWN OF DEATH <i>Randallstown</i>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Randallstown Convalescent Center</i>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home maker</i>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Baltimore</i>			
13c. CITY OR TOWN <i>Pikesville</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS <i>4209 Milford Mill Rd.</i>				14. FATHER'S NAME FIRST MIDDLE LAST <i>Dr. Walter Bosley Rowe</i>			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Carrie (Burruss) Rowe</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			
16b. SOCIAL SECURITY NO <i>212-74-9960</i>				17. INFORMANT ADDRESS <i>Miss Marcia E. Neff 4209 Milford Mill Rd., Baltimore, MD 21208</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CANCER OF PANCREAS WITH METASTASIS</i> <i>1579</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>Hypertension ASCVD - Post Cerebrovascular Accident</i>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>1-5-1967</i> to <i>3-10-1980</i> , that (1) (we) lost saw the deceased alive on <i>2-27-1980</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>V. DECKELBAUM, D.D.</i>				22c. DATE SIGNED <i>3-18-80</i>			
22d. ADDRESS <i>3635 Old Court Rd. Balt 21208 MD.</i>				22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Entombed</i>				23b. DATE <i>3/20/80</i>			
23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cemetery</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Woodlawn Baltimore MD</i>			
24. FUNERAL DIRECTOR NAME <i>Loring Byers Funeral Directors, P.A.</i>				25. DATE REC'D. BY REGISTRAR <i>MAR 19 1980</i>			
26. ADDRESS <i>8728 Liberty Road, Randallstown, MD 21133</i>				27. REGISTRAR'S SIGNATURE <i>Anthony M. Kelly</i>			



( )

UNITED STATES DEPARTMENT OF AGRICULTURE

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

TO THE SECRETARY OF THE INTERIOR

FOR THE YEAR 1907

MAR 1 1908



TO HOSPITAL-OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 0 0 6 1 4 1			
1. DECEASED NAME (TYPE OR PRINT) Berta M. Nesch				2a. DATE OF DEATH MONTH DAY YEAR March 5, 1980				2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR September 26, 1890		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 89 YRS.		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? Germany		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randallstown Convet. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8404 Church Lane 21133	
14. FATHER'S NAME FIRST MIDDLE LAST Wilhelm Riebe				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Mueller							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 217-48-2307		17. INFORMANT Mrs. Hildegard Solimando ADDRESS 8404 Church Lane Randallstown, MD. 21133					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/17/77</u> to <u>12/3</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Howard J. Garber				22c. ADDRESS 5310 Old Court Rd. 21133				22d. DATE SIGNED 3/6/80			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/8/80		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Balto. MD.			
24. FUNERAL DIRECTOR NAME Boring Bayers Funeral Directors, P.A. 8728 Liberty Road Randallstown, MD. 21133				25a. DATE REC'D. BY REGISTRAR MAR 7 1980		25b. REGISTRAR'S SIGNATURE Hildegard Solimando					





*Enclosed*

*[Signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Frances Neubeck			2a. DATE OF DEATH MONTH DAY YEAR March 19, 1980			2b. HOUR 1:53a M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov. 20, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10 CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Harford Co.		13c. CITY OR TOWN Fallston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Frank Rogers			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Montagu			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212-70-5706			17 INFORMANT (Name and Address) Mrs. A. Neubeck Jr. 2021 Falls Grove Way Fallston Maryland 21047			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest, Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Disseminated Intravascular Coagulation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal Failure</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes Mellitus, Probable Malignancy</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <u>March 10</u> , 19 <u>80</u> , to <u>March 19</u> , 19 <u>80</u> , that (we) last saw the deceased alive on <u>March 19</u> , 19 <u>80</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.									
22b. SIGNATURE <u>Mukhtar Khan</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/19/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mukhtar Khan M.D.				22e. ADDRESS 9000 Franklin Square Drive 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 23, 1980		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co. Maryland 21047		23e. DATE REC'D BY REGISTRAR MAR 20 1980	
24 FUNERAL DIRECTOR Joseph William Foster W. Broadway & Williams St. Bel Air, Maryland 21014									



March 1, 1960

Mr. J. Edgar Hoover  
Director, Federal Bureau of Investigation  
Washington, D.C.

Re: [illegible]  
[illegible]  
[illegible]

Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,  
[illegible]

Enclosure

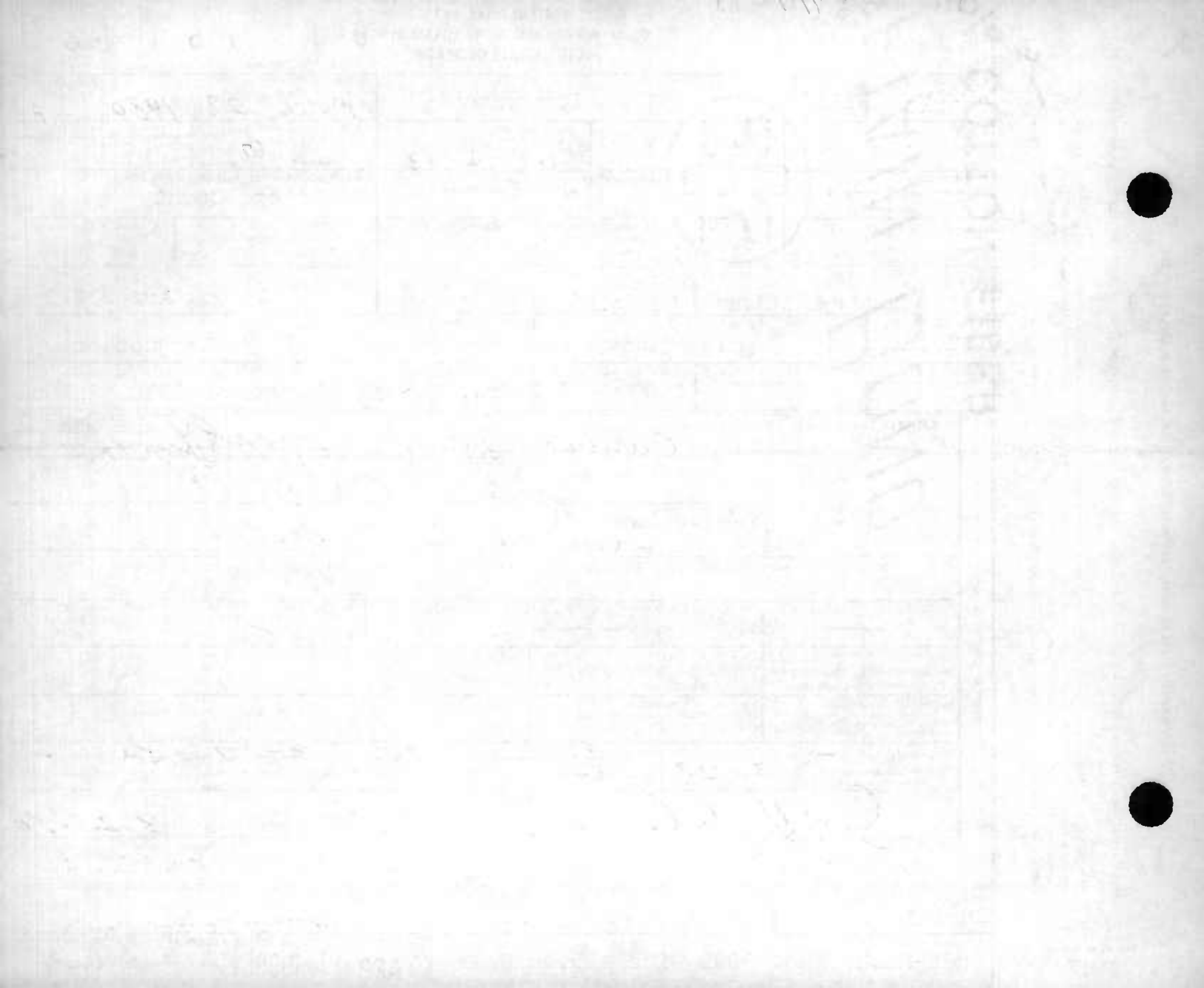
9000  
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME				2b. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)				2b. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
Charles William Nicewonger				March 28, 1980				AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		7. UNDER 24 HRS.	
Male		White		Feb. 1 13		69 67 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Dundalk		1712 Pin Oak Road				Welder					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1712 Pin Oak Ave 21222			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
William C. Nicewonger				Dora Longnecker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				190-03-6441		Mrs. Hannah Nicewonger 1712 Pin Oak 21222					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest - myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Diabetes mellitus</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION					
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		CITY OR TOWN COUNTY STATE					
21a. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET							
22a. I certify that (I) (was hospital) attended the deceased from <u>3-11</u> , 19 <u>75</u> , to <u>3-27</u> , 19 <u>80</u> , that (I) (was) lost											
saw the deceased alive on <u>3-27</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<u>Dr. George Hebeka</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				3-28-80			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Dr. George Hebeka				7839 Wise Ave. Dundalk, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR			
Burial		3/31/80		Meadowridge		Dorsey Howard Maryland		APR 01 1980			
24. FUNERAL DIRECTOR						25b. REGISTRAR'S SIGNATURE					
Duda-Ruck, Inc. 7922 Wise Ave. Dundalk, Md						<u>Jeffrey McCreedy</u>					



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0006144

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>KATHERINE M. NICHOLSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3/22/1980</b>			2b. HOUR <b>1230</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09/27/1952</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care--Rossville</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7604 Old Battle Grove Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Peter Fisher</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Molly Hill</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220.48.6699</b>		17. INFORMANT ADDRESS <b>Elizabeth D. Nicholson---Same as 13e</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest--</b> <b>5990</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Septicemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>UTI</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**CHF**

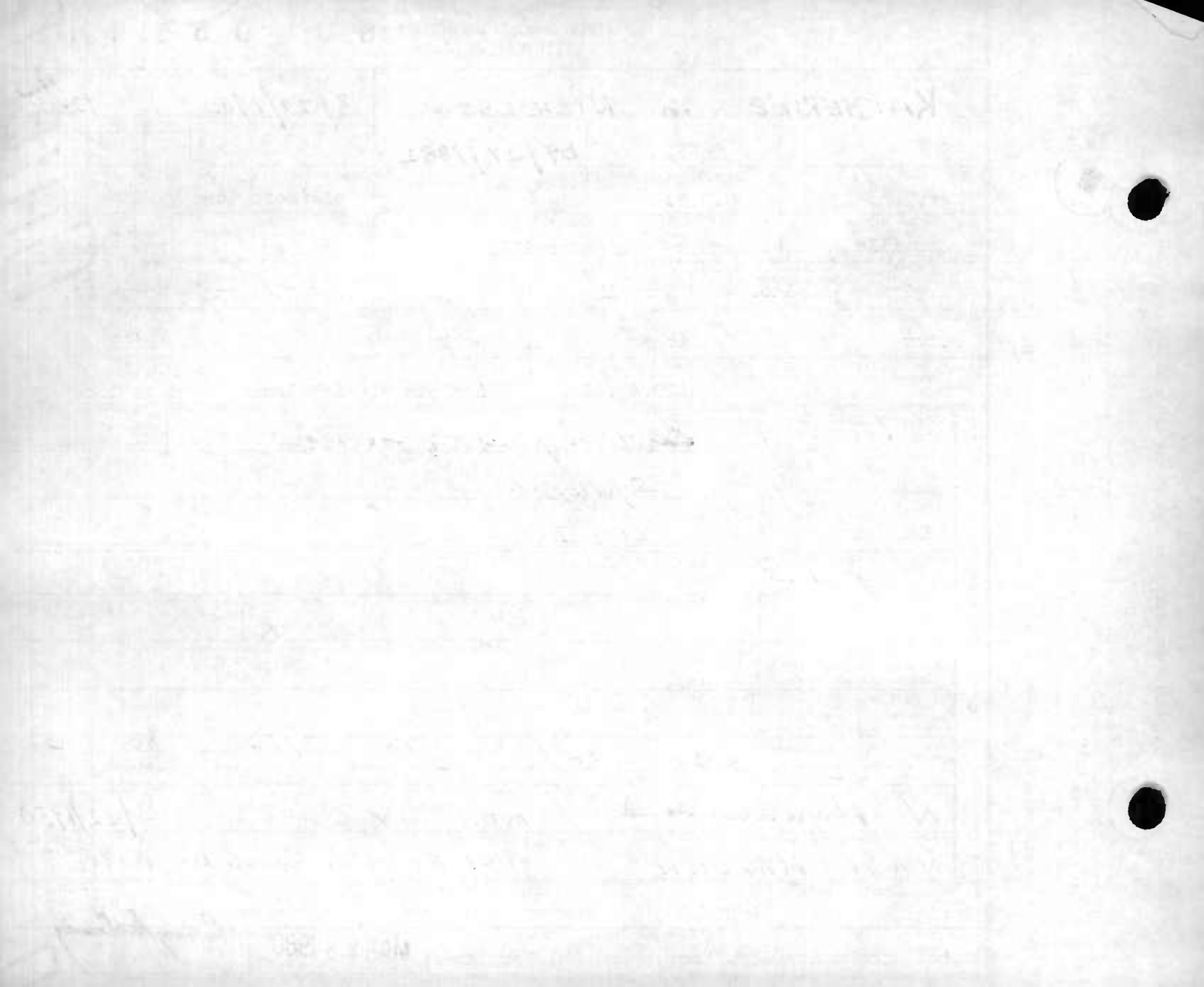
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/16</b> , 19 <b>78</b> , to <b>3/22</b> , 19 <b>80</b> , that (I) <del>was</del> lost saw the deceased alive on <b>3/20</b> , 19 <b>80</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did not) view the body after death.							
22b. SIGNATURE <b>N. Haroun</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3/22/1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NAJI HAROUN</b>				22e. ADDRESS <b>9101 Franklin Square Dr., Balto.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/24/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Walter Brooks Bradley, Inc., Dundalk, Maryland</b>				25a. DATE REC'D BY REGISTRAR <b>MAR 28 1980</b>		25b. SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.





1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
BABY BOY		NULL		3 13 80				2:30P M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male	Cau	MONTH DAY YEAR 3 13 80		YRS MONTHS DAYS		HOURS MIN.		44	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD	U.S.A.			Baltimore County MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Towson	Greater Baltimore Medical Center								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MD	Balto	New Windsor		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1050-1 Nicodemus Rd.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
Edward Eugene Null		Donna Louise							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
				mother					

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Neonatal hypoxia

DUE TO, OR AS A CONSEQUENCE OF

(b) Extreme immaturity

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/13, 19 80, to 3/13, 19 80, that (I) (we) lost saw the deceased alive on 3/13, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		DEGREE		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		3-18-80			
John E. Adams, M.D.		6701 N. Charles St. Towson, Md. 21204					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		3-19-80		GBMC		Towson Md 21204	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
John E. Adams		6701 N Charles		MAR 20 1980 [Signature]			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Office of the Director

Division of Plant Industry

Section of Plant Pathology

Subsection of Plant Pathology

Office of the Chief Plant Pathologist

Office of the Chief Plant Pathologist

Office of the Chief Plant Pathologist

Office of the Chief Plant Pathologist

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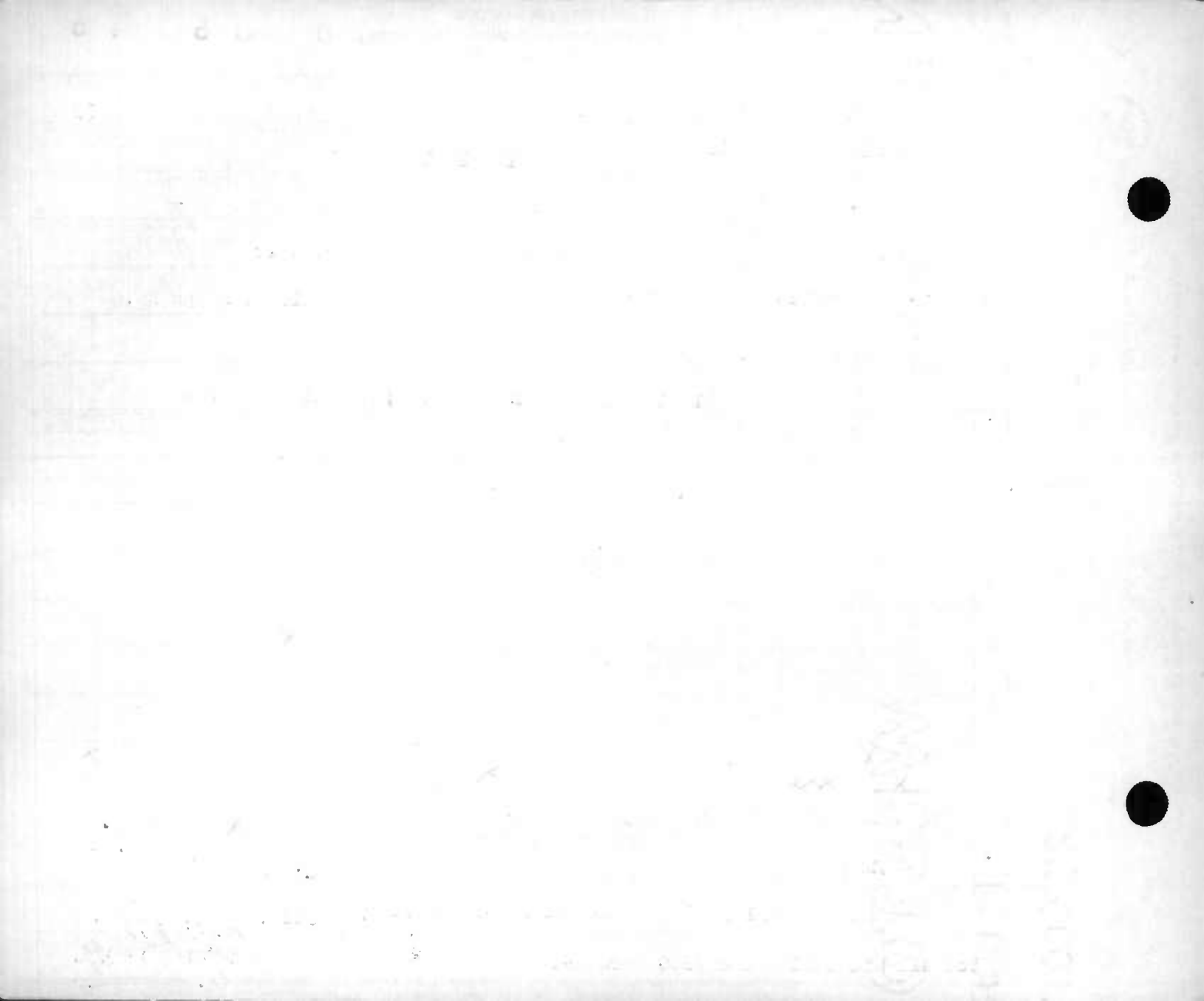


RECEIVED  
DIVISION OF PLANT INDUSTRY  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
LOUISE P. O'CONNELL		MARCH 7, 1980	
3. SEX		2b. HOUR	
Female		8:15 a.m.	
4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	
White	MONTH DAY YEAR 8 13 1892	87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.	USA	BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
TOWSON	SAINT JOSEPH HOSPITAL	Homemaker	
13a. STATE	13b. CITY OR TOWN	13c. STREET ADDRESS	
Md.	Balto	215 E. Joppa Rd.	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
unknown	Chaudron	no	
16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	
213 10 7359D	Stephen M. O'Connell	Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Probable septic shock</u>			
1539			
DUE TO, OR AS A CONSEQUENCE OF			
(b) <u>Dehydration</u>			
DUE TO, OR AS A CONSEQUENCE OF			
(c) <u>Carcinoma of the colon</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
MEDICAL CERTIFICATION			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 6</u> , 19 <u>80</u> , to <u>March 7</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 7</u> , 19 <u>80</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.			
22b. SIGNATURE <u>Natividad D. de Leon, M.D.</u>			22c. DATE SIGNED <u>3/7/80</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Natividad D. de Leon, M.D.			22e. ADDRESS 7620 York Road, Towson, MD 21204
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	3/10/1980	New Cathedral Cemetery	Balto. Md.
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Mitchell-Wiedefeld Home 6500 York Rd.		MAR 12 1980	<u>[Signature]</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 06147			
1. DECEASED NAME (TYPE OR PRINT) CLARA CATHERINE OHRMANN				2a. DATE OF DEATH MARCH 24, 1980				2b. HOUR M			
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH JUNE 26, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5400 ADDINGTON ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5400 ADDINGTON ROAD			
14. FATHER'S NAME FIRST MIDDLE LAST JAMES B. BRUFF				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA GELLER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. (IF YES, GIVE WAR OR DATES)		16c. SOCIAL SECURITY NO 215-44-0502		17. INFORMANT LOUIS W. OHRMANN		5400 ADDINGTON ROAD BALTIMORE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of bladder, metastatic</u> 1541 DUE TO, OR AS A CONSEQUENCE OF (b) <u>from adenocarcinoma rectum</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 mo</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>over</u> 19 <u>70</u> , to <u>March</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>2-19</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Laurence R. Gallagher, M.D.</u>						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-25-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAURENCE R. GALLAGER						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 03-26-80		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR NAME HARRY H. WITZKE				4112 COLUMBIA ROAD ELLCOTT CITY, MD. 21043		25a. DATE REC'D. BY REGISTRAR MAR 28 1980		25b. REGISTRAR'S SIGNATURE <u>Peter J. Helms</u>			

DATE: MARCH 24, 1960

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06148			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARY M. OLERT</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>March 1980</b>		2b. HOUR <b>10 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 8, 1889</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>91 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD</b>							
10. CITY OR TOWN OF DEATH <b>TOWSON</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Uniform Company - Measurer</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1507 Ramblewood Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Olert</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>212-01-4968</b>		17. INFORMANT ADDRESS <b>Mr. Andrew J. Olert 5 Ravens Nest Ct. 21057</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>888 - IMMEDIATE CAUSE (a) Cardiac-Respiratory</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Fractured left Hip</b> (c) <b>Generalized ASCVD</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>4 wks</b> <b>5 yrs</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION <b>2-14-80</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Fractured left Hip</b>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <b>Verified</b>				21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR <b>2 P.M. Feb 8 1980</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fell in own Home</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <b>Home</b>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1507 Ramblewood Rd Baltimore Md</b>							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>Verified</b>													
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>3/5/80</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Charles F. O'Donnell MD.</b>				ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Mar. 8, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck Inc.</b>						ADDRESS <b>Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 11 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06149		
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2b. HOUR
		JOSEPH L. OREFICE					3 14 1980					M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY	YEAR
male	white	3/27/47		32 YRS.	MONTHS DAYS HOURS MIN		3 14 19 80					11:59 P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		USA				Baltimore County						MD.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Baynesville		1845 Denecon Road		Salesman-Home Improvement								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4605 Elsrade Avenue				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME										
Louis J. Orefice		Helen Ross										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
Yes		Army		217 82 4688		Mrs. Helen Ross		Mt. Wilson, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Hanging</u>												
9536 } CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.												
(b) _____												
(c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
		? 3 14 1980 P.M.		subject hanged self								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION								
		house		1845 Denecon Road		Baltimore County, Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED								
Margarita A. Korell		Assistant		3-15-80								
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS										
Margarita A. Korell, M.D.		111 Penn Street										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		COUNTY		STATE		
Burial		3/18/80		Moreland		Balto. County				Md.		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Henry W. Jenkins & Sons Co.		MAR 17 1980		Betsy Kelly								
4905 York Road		21212										

800-955-5844

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06150	
1. DECEASED NAME (TYPE OR PRINT) <b>Phyllis</b>			FIRST <b>G.</b> MIDDLE <b>Orenstein</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> 3 18 80			2b. HOUR <b>6:51</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>APRIL</b> DAY <b>2</b> YEAR <b>1938</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>41</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>3 21 80</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Pikesville</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>803 Judy Lane</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MEAT RAPPER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SHAPIROS</b>	
13a. STATE <b>MD</b>				13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>PIKESVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>803 JUDY LANE</b>	
14. FATHER'S NAME FIRST <b>LESTER</b> MIDDLE <b>RAUSCH</b> LAST <b>RAUSCH</b>				15. MOTHER'S MAIDEN NAME FIRST <b>MARGARET</b> MIDDLE <b>PILLINGS</b> LAST <b>PILLINGS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212-36-4296</b>		17. INFORMANT <b>STANLEY H. ORENSTEIN</b>		ADDRESS <b>SAME</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9509</b> IMMEDIATE CAUSE (a) <b>Intoxication by sinequan and methanol</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 3/18/80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject ingested overdose</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET <b>803 Judy Lane</b> CITY OR TOWN <b>Pikesville</b> COUNTY <b>Balto.</b> STATE <b>Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>				TITLE (SPECIFY) <b>Assistant</b> M.D. MEDICAL EXAMINER				DATE SIGNED <b>3/22/80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>3-25-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEM. PARK</b>		23d. LOCATION CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD</b> STATE <b>MD</b>			
24. FUNERAL DIRECTOR NAME <b>NEWELL FH</b> ADDRESS <b>1100 REISTERSTOWN RD</b>				25a. DNE REC'D BY REGISTRAR <b>MAR 27 1980</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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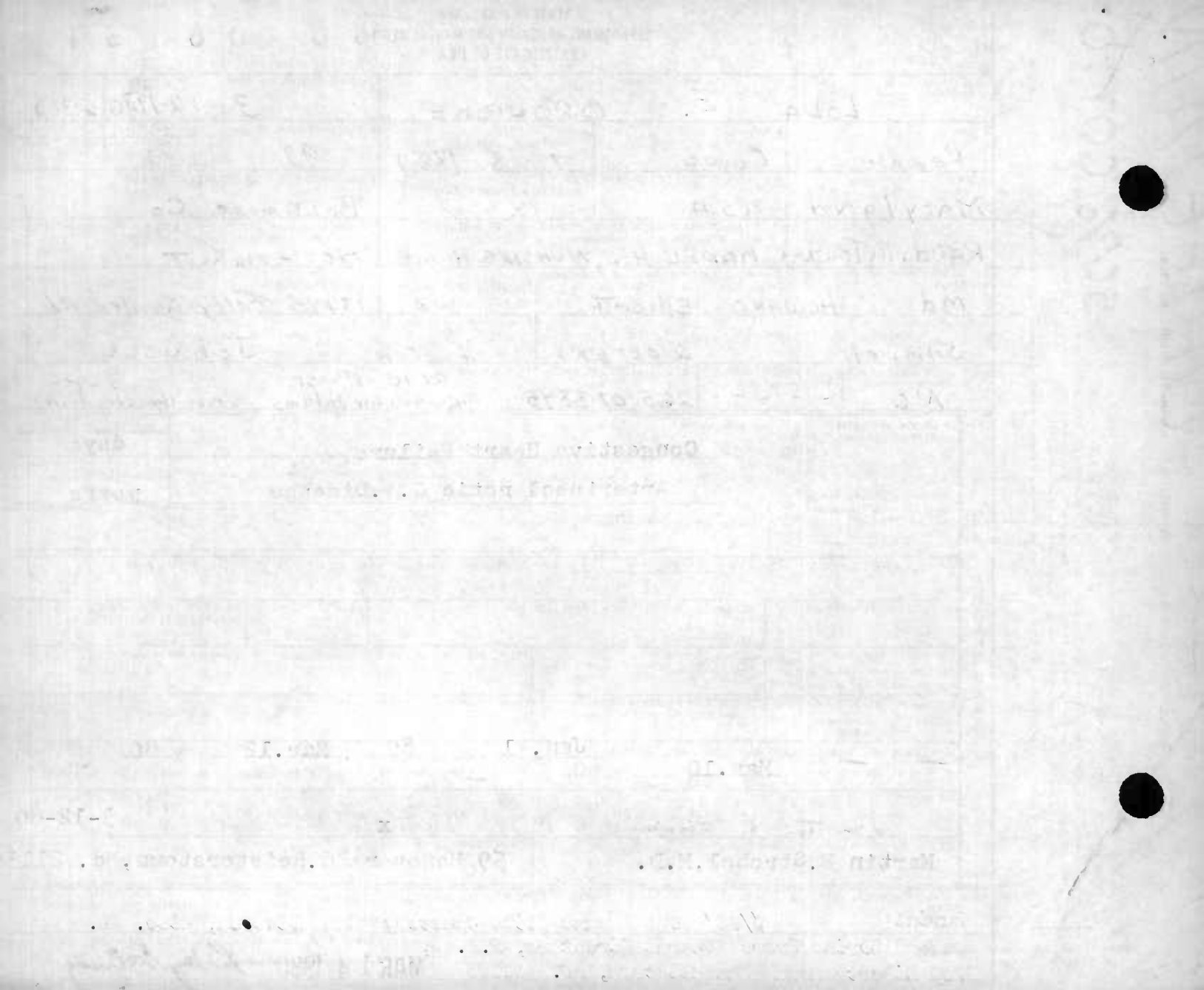
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 6 1 5 1			
FOR STATE REGISTRAR				DECEASED NAME (TYPE OR PRINT) <b>LOLA E. O'ROURKE</b>			
1. SEX <b>Female</b>		2. RACE <b>Cauc.</b>		3. DATE OF BIRTH <b>7-8-1887</b>		4. DATE OF DEATH MONTH DAY YEAR <b>3-12-1980</b>	
5. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.		6. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.		8. TIME OF DEATH <b>6:30 a.m.</b>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co.</b> MD.	
13. CITY OR TOWN OF DEATH <b>Randallstown</b>		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHapel Hill Nursing Home</b>		15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home Maker</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>130 Md HOWARD ELICOTT</b>				18. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19. STREET ADDRESS <b>13495 Folly Quarter Rd</b>				20. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel HOWARD ELICOTT</b>			
21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hester JOHNSON</b>				22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
23. SOCIAL SECURITY NO. <b>265-07-8845</b>				24. INFORMATION ADDRESS <b>2040 13th St. Mrs Archie Adams Vero Beach, Fla. 32960</b>			
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>				26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>			
27. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic C.V. Disease</b>				28. years			
29. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
30. DATE OF OPERATION		31. CONDITION FOR WHICH OPERATION WAS PERFORMED		32. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		33. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
34. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		35. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		36. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
37. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		38. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		39. LOCATION CITY OR TOWN COUNTY STATE			
40. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1</b> , 19 <b>80</b> , to <b>Mar. 12</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>Mar. 10</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
41. SIGNATURE <b>Martin E. Strobel</b> DEGREE <b>M.D.</b>				42. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		43. DATE SIGNED <b>3-12-80</b>	
44. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Martin E. Strobel, M.D.</b>				45. ADDRESS <b>59 Hanover Rd. Reisterstown, Md. 21134</b>			
46. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		47. DATE <b>3/15/80</b>		48. NAME OF CEMETERY OR CREMATORY <b>Mount Olive Cemetery</b>		49. LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown, Balto. MD.</b>	
50. FUNERAL DIRECTOR NAME <b>Ebring Byers Funeral Directors, P.A.</b>				51. DATE REC'D. BY REGISTRAR <b>MAR 14 1980</b>		52. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
53. ADDRESS <b>8728 Liberty Road Randallstown, MD. 21133</b>							





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME FIRST MIDDLE LAST EMMA M. OSTERMANN				7:45P <sub>M</sub>			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 30, 1901		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7c CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH TOWSON Baltimore Co., Md.	
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 N. CHARLES STREET		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY -----	
13a STATE Maryland		13b COUNTY -----		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John Eslinger		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Swift		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 214-54-3318	
17 INFORMANT Howard F. Ostermann		ADDRESS 3654 Dudley Avenue		21213			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1749</u> <u>METASTATIC CARCINOMA OF BREAST</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>03/06</u> 19 <u>80</u> , to <u>03/12</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>03/12</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>[Signature]</u> DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 03/12/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. S.P. GIRDHAR				22e ADDRESS GREATER BALTIMORE MEDICAL CENTER			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 15, 80		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24 FUNERAL DIRECTOR NAME Dippel Brothers, Inc.				ADDRESS 7110 Belair Rd. 21206		25. DATE REC'D. BY REGISTRAR MAR 14 1980	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

Shippel Brothers, Inc. 7410 Belair Rd. Baltimore, Md. 21208

Burial Jan 15, 80 Calawn Cemetery Baltimore, Maryland

Dr. C.P. H... ..

03/12/80

03/12/80

03/06/80

03/12/80

X

INVESTIGATIVE DIVISION OF FBI

No 244-24-3318 Howard F. Ostermann 3624 Dudley Avenue Baltimore, Md. 21208

John Eslinger

Jennie Swift

Maryland ----- Baltimore X 524 N. Rose Street

MARYLAND

7111 CHARLES STREET

Housewife

Maryland  
Baltimore

U.S.A.

Female White Dec. 30, 1904

78

STVA 11. 03 12 80 7:45

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 0 0 6 1 5 3		CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Kimberly Jean OWENS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>March 7, 1980</b>		2b. HOUR <b>9:05 P.M.</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>January 5, 1961</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>19</b> YRS.		7 UNDER 1 YEAR MONTHS DAYS <b>19</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD			
10 CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Essex</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Bal., Md. 21221 60 Orville Road</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>James S. Owens Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth A. Reinhardt</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-80-9801</b>		17 INFORMANT <b>Father: James S. Owens Sr.</b>		ADDRESS <b>Balt., Md. 21221 60 Orville Road</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
3440 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aspiration</b> } DUE TO, OR AS A CONSEQUENCE OF (c) <b>Paralysis</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Multiple fibromatosis with secondary hydrocephalus and quadraplegia</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 4, 1980</b> , to <b>March 7, 1980</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 7, 1980</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do) view the body after death.									
22b. SIGNATURE <b>Randall E. Cronin, Jr.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>3/7/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Randall Cronin MD</b>				22e. ADDRESS <b>9000 Franklin Square Dr., 21237</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Mar 10 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>White Marsh Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>				ADDRESS <b>Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 11 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



Female	White	January 2, 1901	19	X
Maryland	U.S.A.			
Hossville	Franklin Square Hospital	Student		
Maryland	Baltimore	Reed	X	
James	James M.	Lincoln	A.	
	220-80-8801	James S. James M.	60 Oriole Road	
		Father:	Balt., Md. 21221	
			Reinhardt	

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8006154		
1- FOR STATE REGISTRAR					CERTIFICATE OF DEATH						REG. NO.	
1- DECEASED NAME (TYPE OR PRINT) <b>ELANOR ELINOR V. PALMER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>3-6-80</b>					2b. HOUR <b>7:25 PM</b>		
3 SEX <b>Female</b>		4 RACE <b>Negro</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>10 20 01</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		7 IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		8 IF UNDER 4 HRS. HOURS MIN.		
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ba Co MD</b>		9b CITIZEN OF WHAT COUNTRY? <b>USA</b>		10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Ba Co County</b> MD.						
10 CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Ba Co County Gen Hosp</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Net Factory</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>WAGON</b>				
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD</b>				13b COUNTY <b>Ba Co</b>		13c CITY OR TOWN <b>Ba Co</b>		13d INSIDE CITY LIMITS? <b>YES</b> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1034 ELLICOTT DR.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Norman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MISSOURI DABACK</b>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>217-20-9772</b>		17 INFORMANT ADDRESS <b>CHARLOTTE ADAMS 1034 ELLICOTT DR</b>								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTIC SHOCK</b> <b>4-86-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>URINARY TRACT INFECTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>PNEUMONIA</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b>												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>3-5</b> 19 <b>80</b> , to <b>3-6</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>3-6</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Conanan</b>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3-6-80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ORLANDO B. CONANAN MD</b>				22e. ADDRESS <b>BCH - RANDALLSTOWN, MD 21133</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/10/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT Auburn</b>		23d. LOCATION CITY OR TOWN <b>Ba Co MD</b>		COUNTY		STATE		
24 FUNERAL DIRECTOR NAME <b>Marshall P. Langs</b>				ADDRESS <b>685 N 91st St</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 11 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>		

Figure 1 consists of two line graphs, (a) and (b), plotting the rate of reaction against temperature. Both graphs have a y-axis labeled 'Rate of reaction' and an x-axis labeled 'Temperature / °C'.

Graph (a) shows a bell-shaped curve. The rate of reaction starts at 0 at 0°C, rises to a peak of 10 at 30°C, and then falls to 0 at 40°C. The curve is labeled 'a'.

Graph (b) shows a curve that rises sharply from 0 at 0°C to a value of 10 at 30°C, and then levels off at 10 for temperatures up to 40°C. The curve is labeled 'b'.

7

Kindness is the best country for him who has a good heart.

1

60-275-28



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					8 0 0 6 1 5 5				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
Marion M. Parker					March 25, 1980				
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
F		W		Jan. 6, 1907		73 YRS.		4 <sup>00</sup> A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Baltimore, Md.		USA				Baltimore Co., MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Lutherville		20 Lochmoor Ct.				Homemaker			
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		
Md.					Baltimore		Lutherville		
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Henry W. Matthews					Marion Theresa Guth				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS		
No							Mr. Peter Parker 1002 ?Winding Way		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>CVA</u>								1 hour	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis, cerebral</u>								6 mos	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ca Breast</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
			19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>06/1</u> 19 <u>62</u> , to <u>3/25</u> 19 <u>80</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>3/24</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>William F. Fritz</u>			<u>an</u>					<u>3/26/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
William F. Fritz, M.D.					2 W. University Pkwy.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		3/27/80		Sherwood Epis. Church		Cockeysville, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS					25. DATE REG'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.					MAR 31 1980		<u>Henry McCreedy</u>		



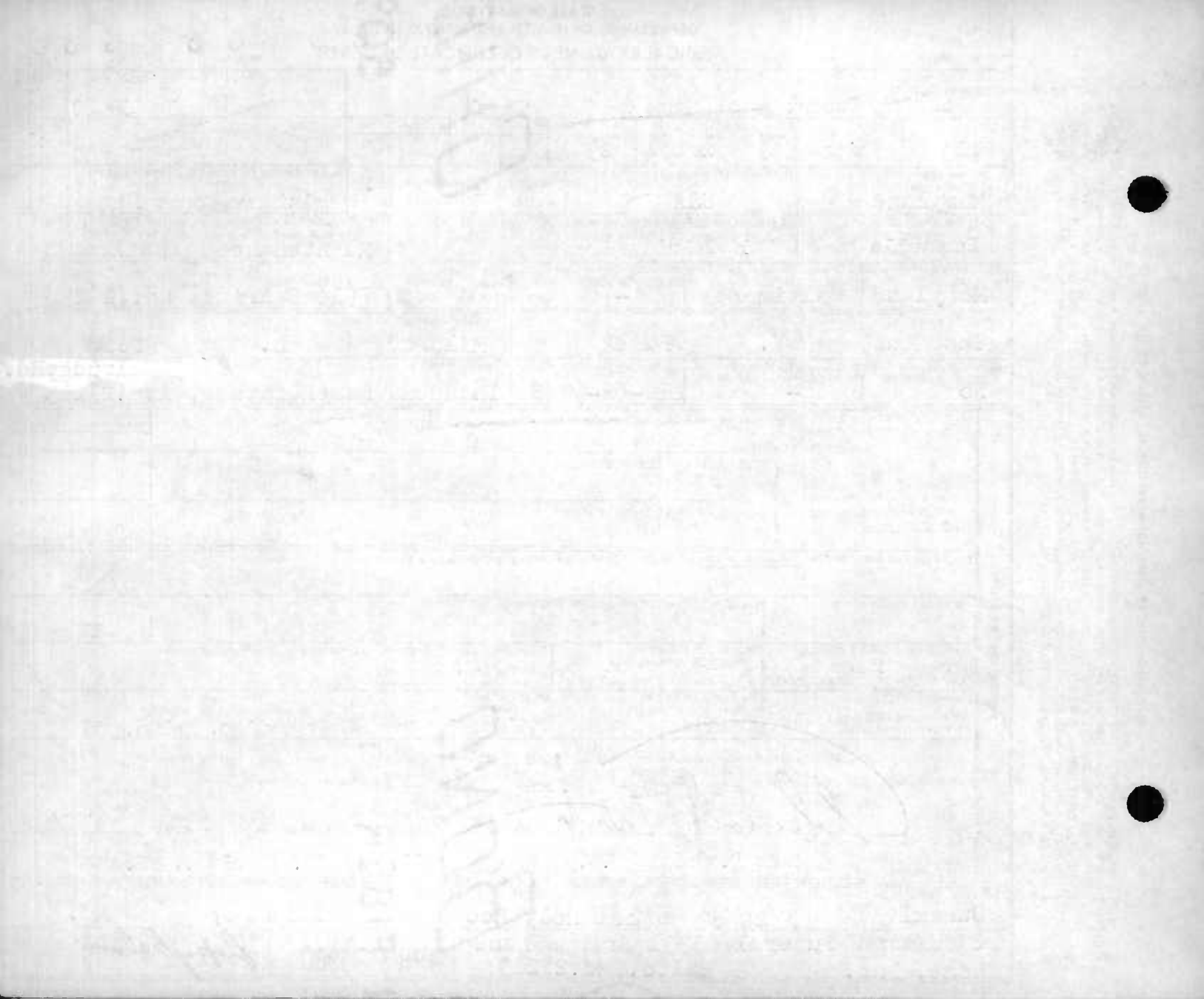
08/25/68

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, RELEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 3 FOR YOUR FILES. GIVE PAGES 1 AND 2 TO THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		3. DATE OF BIRTH		4. AGE (IN YEARS)		5. IF UNDER 1 YR.		6. IF UNDER 24 HRS.		7. DATE PRONOUNCED DEAD		2b. HOUR	
1b. DECEASED NAME (TYPE OR PRINT)		2b. DATE KNOWN OF DEATH		3. DATE OF BIRTH		4. AGE (IN YEARS)		5. IF UNDER 1 YR.		6. IF UNDER 24 HRS.		7. DATE PRONOUNCED DEAD		2b. HOUR	
Robert Joseph Pasek		3 23 80		9 2 54		25 YRS.		MONTHS		DAYS		HOURS		MIN.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD		2b. HOUR	
Male		White		9 2 54		25 YRS.		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD	
Maryland		USA		MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		Baltimore County,		MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Parkville		7916 Belridge Road		Maintenance		Railroad									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland		Baltimore		-		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7916 Belridge Rd., 21236							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Thaddeus V. Pasek		Mildred L. Drozd		No		214-62-9757		Thaddeus Pasek, father,		2605 Kentucky Ave. 21213					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
9532		Gunshot wound of head (rifle)		DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.				(b)		DUE TO, OR AS A CONSEQUENCE OF									
				(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		self inflicted									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		7916 Belridge Rd, Parkville, Balto., MD									
22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		3/27/80									
EXAMINER'S NAME		ADDRESS													
Thomas D. Smith, M.D.		111 Penn St. Balto., MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION									
Burial		3/29/80		Most Holy Redeemer		Baltimore, Md.									
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Schimunek Funeral Home, Inc.		APR 1 1980		Duffy, Anthony											



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

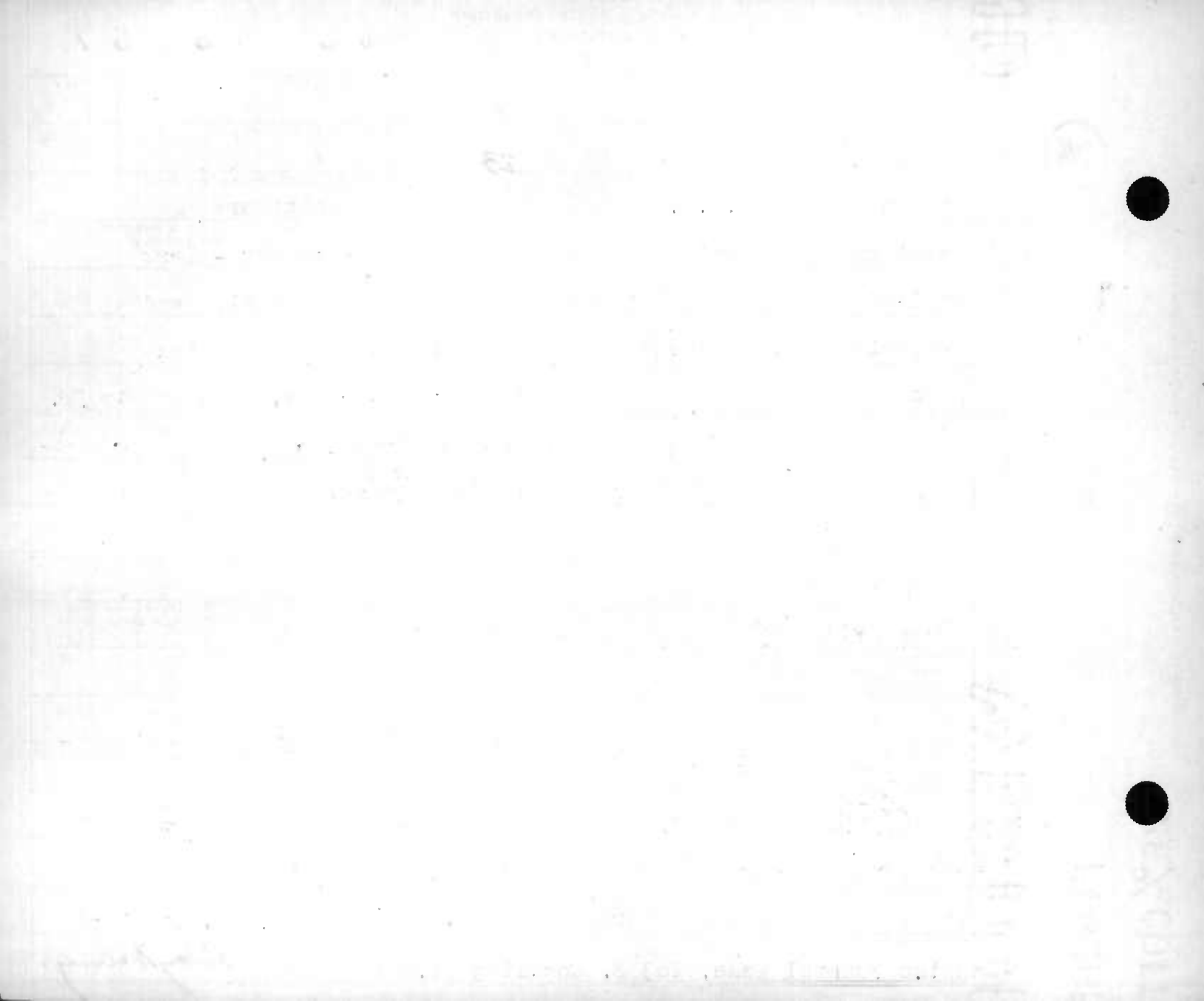
FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Lena</i> FIRST <i>Pasenger</i> MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR <i>3/6/80</i>		2b. HOUR <i>11</i> MIN <i>10</i> AM
3. SEX <i>Female</i>	4. RACE <i>Cauc.</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>4-23-70</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS.	IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i> MD.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Perring Parkway Nursing</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>homemaker - Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Maryland</i>		13b. COUNTY <input checked="" type="checkbox"/>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>3212 Belair Road</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Benjamin Green</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sarah Rink</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Miss Leah Pasenger, 3212 Belair Rd.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MALIGNANT METASTASES -</i> <i>1539</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CANCER of the Colon</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>14R-</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mos -</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>ANEMIA -</i>					
19a. DATE OF OPERATION <i>July 1979</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED. <i>CANCER of Colon Resection</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/6/80</i> to <i>3/6/80</i> , that (I) (we) lost saw the deceased alive on above, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.					
22b. SIGNATURE <i>Anthony F. Carozza MD</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>3/7/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Anthony F. Carozza MD</i>		22e. ADDRESS <i>1801 Westview Rd Baltimore 21234</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>3/9/80</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Cem. of</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>Zannino Funeral Home</i>		ADDRESS <i>263 S. Conkling St.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 10 1980</i>	25b. REGISTRAR'S SIGNATURE <i>History Maloney</i>

BP.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

00006158

REG. NO.

1- FOR  
STATE  
REGISTRAR

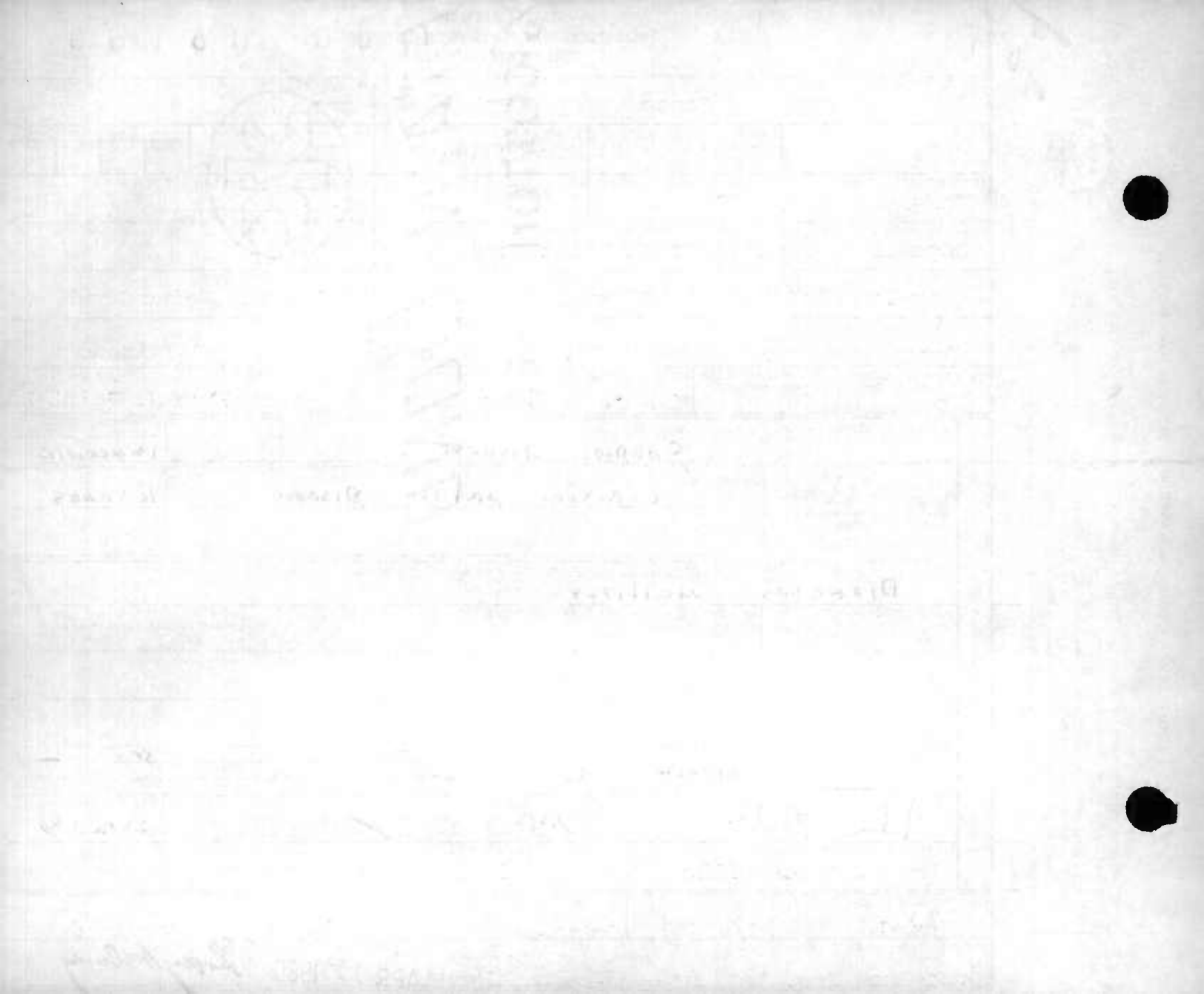
1. DECEASED NAME (TYPE OR PRINT) <b>Joseph James Patti Jr.</b>			7a. DATE OF DEATH MONTH DAY YEAR <b>March 28, 1980</b>		7b. HOUR M <b></b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>May 20 1901</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b>	IF UNDER 1 YEAR MONTHS DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
10 CITY OR TOWN OF DEATH <b>Edgemere</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7101 North Point Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Lawyer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b></b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Edgemere</b>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Joseph James Patti Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Antonia Palmisano</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-38-3906</b>		17. INFORMANT ADDRESS <b>21219</b> <b>Mrs Lilyan G. Patti 7101 N. Point Rd</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arterial Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>14 HOURS</b> <b>10 YEARS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>DIPHTHERIA MELITUS</b>					
19a. DATE OF OPERATION <b></b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b></b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b></b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b></b>	
22a. I certify that (1) (this hospital) attended the deceased from <b>19 70</b> to <b>19 80</b> , that (1) <del>was</del> lost saw the deceased alive on <b>MARCH</b> 19 <b>80</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>was</del> did not view the body after death.					
27b. SIGNATURE <b>Dr. J. Dixon Hills</b>				27c. DATE SIGNED <b>28 MAR 80</b>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. J. Dixon Hills</b>				27e. ADDRESS <b>3501 St. Paul Street</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/31/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck Inc.</b>		ADDRESS <b>7922 Wise Ave Dundalk Md</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
25a. DATE REC'D. BY REGISTRAR <b>APR 01 1980</b>				25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SYLVIA			2a. DATE OF DEATH MONTH DAY YEAR March 16, 80			2b. HOUR 2:20 PM		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR AUG. 8, 1897		
6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.			7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA			7b. CITIZEN OF WHAT COUNTRY? USA		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH RANDALLSTOWN			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		
12b. KIND OF BUSINESS OR INDUSTRY AT HOME			13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13d. STREET ADDRESS 7020 PARK HTS. AVE. 21215			13e. STREET ADDRESS 1ST FL.					
14. FATHER'S NAME FIRST MIDDLE LAST MAX DEMING			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRIEDA UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT MR. MITCHELL PENN 8 KITTRIDGE CT. RANDALLSTOWN MD 21133		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension of the R kidney</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anterolateral Coronary artery disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>March 15, 1980</u> to <u>March 16, 1980</u> , that (I) (we) lost saw the deceased alive on <u>March 16, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Sharon Pournotabed, M.D.</u>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3-16-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHARON POURNOTABED			22e. ADDRESS Baltimore County Gen. Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAR. 17, 1980			23c. NAME OF CEMETERY OR CREMATORY MOSES MONTEFIORE WOODMOOR		
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			24. FUNERAL HOME NAME ADDRESS MOSES MONTEFIORE & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215					
25. DATE RECEIVED BY REGISTRAR MAR 18 1980			25b. REGISTRAR'S SIGNATURE <u>Robert M. Kelly</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		M	
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		ANNE MARGARET PERKINS		MARCH 17, 1980			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
FEMALE		WHITE		JULY 15, 1901		78 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.	
IRELAND		USA				BALTIMORE COUNTY			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON		7733 GREEN VIEW TERRACE		TEACHER					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD.		BALTIMORE		TOWSON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7733 GREEN VIEW TERRACE	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS	
THOMAS		JACKSON		AGNES		McKINSTRY		MRS. AGNES SHERA 1903 SHERWICK RD. 21204	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19		20		21		22	
PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		MINUTES	
410-		CARDIAC ARREST		MYOCARDIAL INFARCTION		MINUTES			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		YEARS			
		(c)		CORONARY HEART DISEASE					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		HYPERTENSION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET					
22. I certify that (I) (this hospital) attended the deceased from 1/30, 1961 to 3/17, 1980, that (I) (we) last saw the deceased alive on 7/26, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
Donald L. Somerville, MD.				3/18/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
DONALD L. SOMERVILLE		26 W. PA. AVE TOWSON, MD 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN COUNTY STATE	
BURIAL		MARCH 22, 80		UNION CEMETERY		AMESBURY		MASS.	
24 FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
NAME ADDRESS		MAR 22 1980		notary/kechady					
MITCHELL-WIEDEFELD HOME		6500 YORK RD. 21212							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO.		06161					
1 DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH				2b HOUR	
FIRST MIDDLE LAST Peterson Harold David PETERSEN				MONTH DAY YEAR MARCH 2, 1980				1 P M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR	
Male		White		MONTH DAY YEAR Oct. 22, 1895		84 YRS.		# UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
New York		USA				Baltimore County		MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Parkville		Perring Parkway Nursing Home				Teacher		Education	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b INSIDE CITY LIMITS?		13c STREET ADDRESS			
13a STATE 13b COUNTY 13c CITY OR TOWN Maryland Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3654 Ellerslie Avenue			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST John Peterson				FIRST MIDDLE LAST Agusta Greipe					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
No				219 26 54111		Ronald L. Peterson Towson, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i>								<i>sudden</i>	
410- DUE TO, OR AS A CONSEQUENCE OF (b) <i>coronary heart dis.</i>								12 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
<i>chronic obstructive lung dis.</i>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				19c AUTOPSY?		20a IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED					
		HOUR A.M. MONTH DAY YEAR P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY		21f LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from May 5, 1968, to Jan 3, 1980, that (I) (we) last saw the deceased alive on Feb 9, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE						22c DATE SIGNED			
Dr. William F. Renner, M.D.						3/5/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT)						22e ADDRESS			
Dr. William F. Renner, M.D.						3222 St. Paul Street Balto., Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		23e COUNTY STATE	
Cremation		3/6/80		Greenmount		Balto., Md.			
24 FUNERAL DIRECTOR				25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
NAME ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212				MAR 4 1980		History/Kalinsky			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0006162	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Anthony J. Petro</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>March 24, 1980</b>			2b. HOUR <b>5:58 AM</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9-1-08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Supervisor</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Tailoring</b>		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1117 Ramblewood Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Petro</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clorinda Varrato</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212-10-2601</b>		17. INFORMANT ADDRESS <b>Mary Ann Petro, 1117 Ramblewood Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ANTERIOR WALL MYOCARDIAL INFARCTION</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 HOURS</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <b>N</b> (this hospital) attended the deceased from <b>March 23, 1980</b> to <b>March 24, 1980</b> , that <b>we</b> last saw the deceased alive on <b>March 24, 1980</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>we</b> (I) (did) (do) view the body after death.											
22b. SIGNATURE <b>James Kleeman M.D.</b>						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-24-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James Kleeman, M.D.</b>						22e. ADDRESS <b>7620 York Rd. Towson, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>		23b. DATE <b>3-27-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Patrick McCreedy</b>			





OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D. C. 20315

100-100000-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO. 8 0 0 6 1 6 3								
1. DECEASED NAME (TYPE OR PRINT)		FIRST Esther		MIDDLE Mae		LAST Pfieffer		2c. DATE OF DEATH MONTH DAY YEAR		
ESTHER		mae		Pfieffer		3-26-80		2b. HOUR 5:45 AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		
Female		White		5-3-89		90 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.				Baltimore County MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville		Shady Nook Nursing Home				Seamstress ret				
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland					Baltimore		Arbutus		13e. STREET ADDRESS	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
George L. Kirby					Mary K. Biddison					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no			217-18-0797		Mrs. Otelia A. Whittle, 4905 Alson Dr., Balto, Md. 21229					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>inanition</u>									2 mo.	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>depression</u>									7 mo.	
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>cholelithiasis</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>11-24</u> , 19 <u>78</u> , to <u>3-26</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>7-25</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE DEGREE						22c. DATE SIGNED				
<u>David R. Moseman, M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						3-26-80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS				
<u>David R. Moseman, M.D.</u>						<u>4713 Leekle Ave. 21227</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation			3-27-1980		Loudon Park Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Hubbard Funeral Home Inc. 4107 Wilkens Ave 21229						MAR 28 1980		<u>History McCready</u>		

MEDICAL CERTIFICATION

4307 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 006164			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 3 2 80			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Louis H. Pinkney				2b. HOUR 11:45 AM			
3 SEX male		4 RACE Negro		5 DATE OF BIRTH MONTH DAY YEAR 7 29 07		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10 CITY OR TOWN OF DEATH BALTIMORE CO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Valley View Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. POST OFFICE		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND		13b COUNTY BALTIMORE		13c CITY OR TOWN N/A		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST LOUIS H. PINKNEY		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLOSSIE E. CROMWELL		13e STREET ADDRESS 5898 OLD FREDERICK ROAD			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. W.W.II 216-07-7196		17 INFORMANT ADDRESS MR. LOUIS H. PINKNEY 5898 OLD FREDERICK ROAD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1536 Hepatic coma				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of Right colon							
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Live Metastases old stroke							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 2/26/80 to 3/2/80, that (I) (we) lost saw the deceased alive on 3/2/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b SIGNATURE Vincent Nguyen				DEGREE		22c DATE SIGNED 3/3/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) VIN NGUYEN				22e ADDRESS 6 Lin Low Ct Towson Md 21204			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE 3/6/80		23c NAME OF CEMETERY OR CREMATORY Loudon Park		23d LOCATION CITY OR TOWN COUNTY STATE Balt. Md.	
24 FUNERAL DIRECTOR NAME Leroy O. Dyett				24b ADDRESS 4600 Liberty Hgts Ave		25a DATE REC'D. BY REGISTRAR MAR 4 1980	
				25b REGISTRAR'S SIGNATURE			



Left side  
Right side  
Right side

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Right side

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Right side

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>LEONA SEAL POE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 4 '80</b>			2b. HOUR <b>2:30AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 4, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC-6701 N. CHARLES ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Parks &amp; Hull</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3008 E. Fayette Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ulysses G. Seal</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine D. Schaffer</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212 03 7840</b>		17. INFORMANT ADDRESS <b>Mr. William G. Geyer, Jr. Balto., Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> <b>486-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>2-29</b> , 19 <b>80</b> , to <b>3-4</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>3-4</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Basem Kayali</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>3/4/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BASEM KAYALI, M.D.</b>				22e. ADDRESS <b>GBMC-6701 N. CHARLES ST.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/7/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 4 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i>			
4905 York Road Balto., Md. 21212									

STAFF COUNTY

CHURCHMAN, H. CHARLES, JR.

102 DT

RECEIVED

1964

CHURCHMAN, H. CHARLES, JR.

102 DT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be not filed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 8006166						
1. DECEASED NAME (TYPE OR PRINT) HESTER B. POND			2a. DATE OF DEATH March 9, 1980				2b. HOUR 8:10P M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH October 1, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care-Ruxton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN 21204		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 40 Acorn Circle	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Brown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester Peebles				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT Adelia Pond		17. ADDRESS 40 Acorn Circle 21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchitis</u> <u>4871</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>INFLUENZA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Days</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Multiple criz's - Generalized Arteriosclerosis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 68</u> , to <u>Mar 9</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Mar 7</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u> MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3-11-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.J. Venable, M.D.				22e. ADDRESS 7215 York Road 823-3101					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 12, '80		23c. NAME OF CEMETERY OR CREMATORY Blanford Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Petersburg, Virginia			
24. FUNERAL DIRECTOR NAME William E. Johnson				ADDRESS 8521 Loch Raven Blvd.		25a. DATE REC'D. BY REGISTRAR MAR 18 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>VERA D. PONENTO</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>31</b> YEAR <b>80</b>		2b. HOUR <b>8:35AM</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>September</b> DAY <b>4</b> YEAR <b>1919</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>England</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10 CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>G.B.M.C.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Store Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sporting Goods</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>21234</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1504 Taylor Avenue</b>
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Dickinson</b> LAST <b>Dickinson</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Agnes</b> MIDDLE <b>Fisher</b> LAST <b>Fisher</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>165-18-0827</b>		17. INFORMANT ADDRESS <b>Gail M. Price 7210 Sindall Road 21234</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> <b>2028</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>GENERALIZED LYMPHOMA STAGE 1V</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 YRS</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3-27</b> , 19 <b>80</b> , to <b>3-31</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>3-31</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Dr. Ahmed Shafik</b> DEGREE <b>MD</b>				22c. DATE SIGNED <b>3/31/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. AHMED SHAFIK</b>				22e. ADDRESS <b>Dr. George Richards</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>		23b. DATE <b>April 3, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>	
23d. LOCATION CITY OR TOWN <b>Baltimore County, Md.</b>		23e. COUNTY <b>Baltimore</b>		23f. STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b> ADDRESS <b>8521 Loch Raven Blvd. 21204</b>			25a. DATE REC'D. BY REGISTRAR <b>APR 2 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

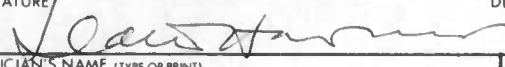

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
SYLVESTER Charles POPE					03 10 80					5:45 P M	
1. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		# UNDER 1 YEAR		
Male		CAUC.		01 05 21			59 YRS.		# UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.					Baltimore County MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Randallstown,		Balto. County Gen. Hospital								Security Manager-C & P	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS		Telephone Co.			
Maryland		Carroll		Eldersburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6703 Autumn View Ct.			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Sylvester Pope				Luella Castle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, AND OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Yes				WWII		217-16-4691		Mrs. Ruth V. Pope 21784 6703 Autumn View Ct. Eldersburg, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myo. Infarction</u> <u>410-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardio. Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
			P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>3-8-</u> 19 <u>80</u> to <u>3-10</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>3-10-</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE							DEGREE		22c. DATE SIGNED		
<u>[Signature]</u>									3-10-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)							22e. ADDRESS				
DR. S. D. PATEL							Bal. County Gen. Hosp 820 Crown Rd. Randallstown - 21132				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			3/13/80		Lake View Mem. Park			Sykesville Carroll MD.			
24. FUNERAL DIRECTOR <u>Loring Byers</u> Funeral Directors, P.A., BY REGISTRAR <u>[Signature]</u> 8728 Liberty Rd. Randallstown, MD. 21139 MAR 11 1980											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

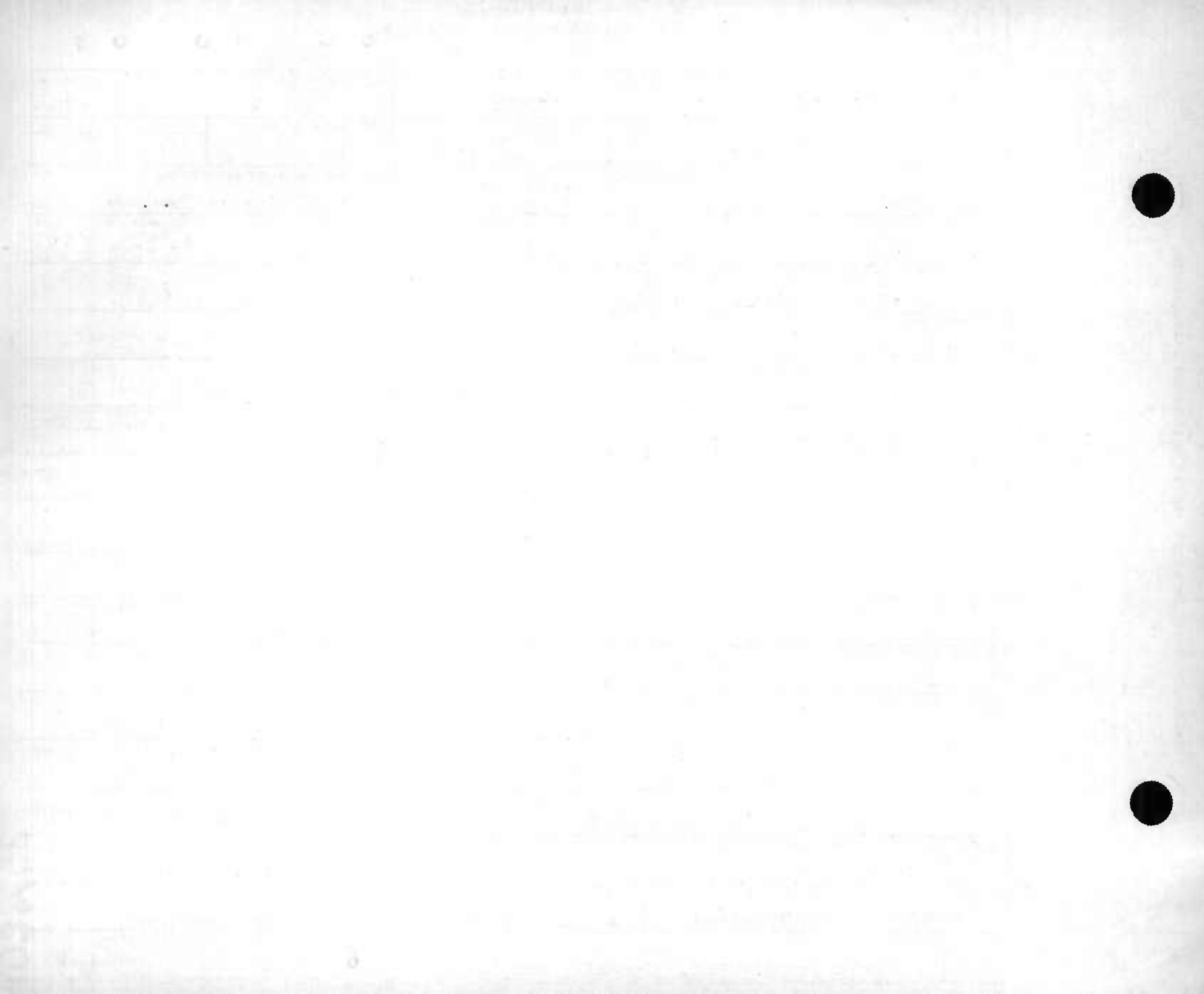
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 0 0 6 1 6 9	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Elizabeth P. POTTER</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>3 5 80</b>		2b. HOUR <b>9:50</b>		a	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 25 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Scotland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Photo-Aerial graphy</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6830 Belclare Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alexander Patrick</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes Thompson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212/20/3763</b>		17. INFORMANT ADDRESS <b>Nancy Stricklin same as 13 e,</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of colon</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>3/27</b> , 19 <b>80</b> , to <b>3/5</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>3/5</b> , 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3/5/80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dante Haw, M.D.</b>				22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/8/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Walter Brooks Bradley Inc. Dundalk, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 6 1980</b>		25b. REGISTRAR'S SIGNATURE 					

BP

DHMH-16 20M  
(VRA 15, 4) 7/78





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Amie Elizabeth Price			2a. DATE OF DEATH MONTH DAY YEAR 3 30 80			2b. HOUR 12 30 AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 24 22		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							

13a. STATE Md.			13b. COUNTY City		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2609 Maisel St.		
14. FATHER'S NAME FIRST MIDDLE LAST Victor E. Wikins						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Wikins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-12-6878		17. INFORMANT ADDRESS S. Glenford Price S/A					

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant carcinoma</u> 1719 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Partial intestinal obstruction</u> (c) <u>Leiomysarcoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from 3-24-1980, to 3-30-1980, that (I) (we) last saw the deceased alive on 3-30-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Prem Kumar Gulati MD			DEGREE MD			22c. DATE SIGNED 3-30-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PREM K. GULATI			22e. ADDRESS ST. AGNES HOSP.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/4/80		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md.	
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24. FUNERAL DIRECTOR NAME ADDRESS Charles A. Rice 1300 Eutaw Place			25a. DATE REC'D. BY REGISTRAR APR 2 1980			25b. REGISTRAR'S SIGNATURE [Signature]		
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

• 2 • 3 • 4 • 5 • 6

[illegible]

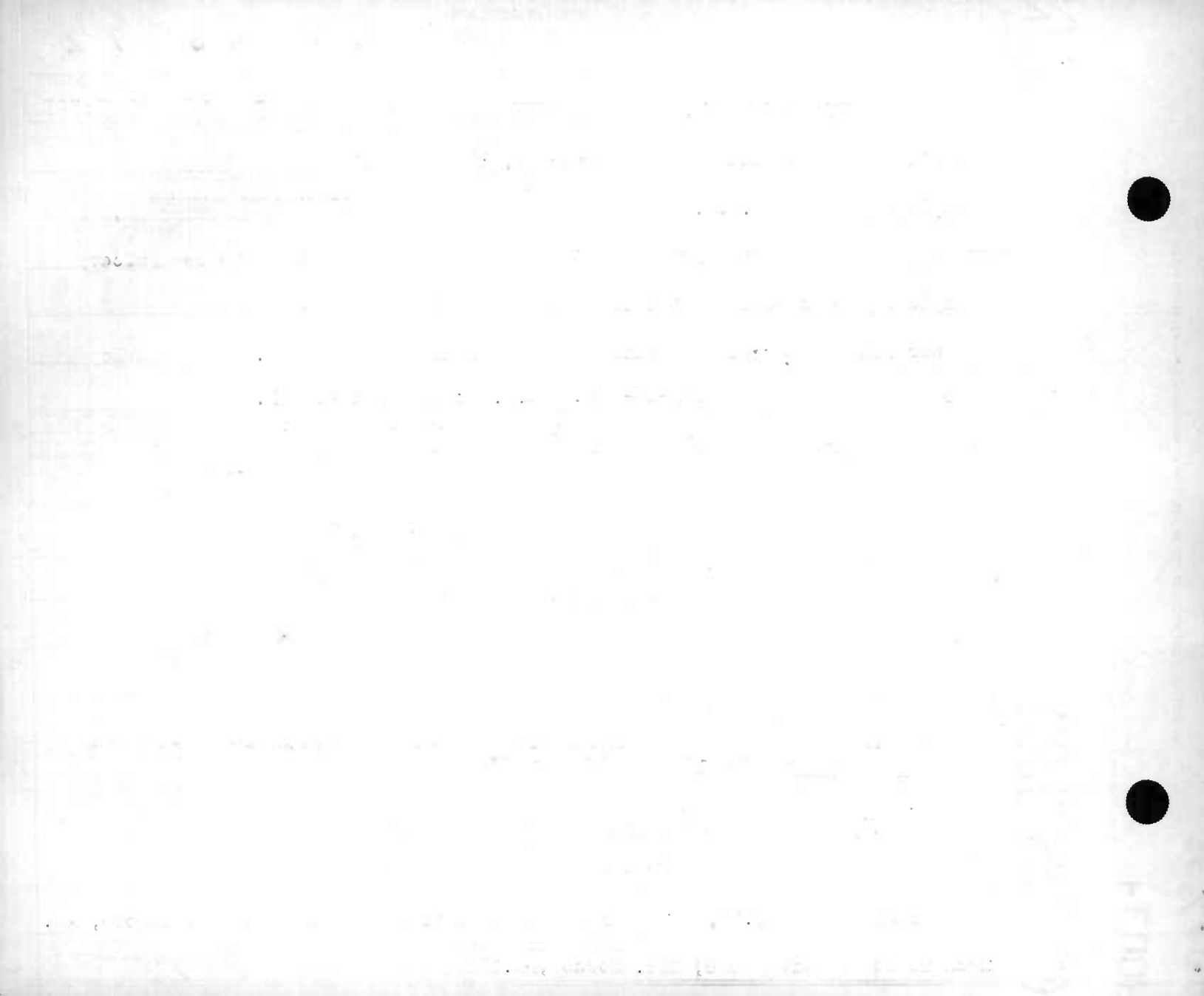
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06171	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST David W. Price, Sr.										2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <input type="checkbox"/> March 11, 1980 11:45 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 12 1922		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 57		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH Towson				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14 Oberlin Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner Gynn Oak Amusement Park		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 14 Oberlin Court	
14. FATHER'S NAME FIRST MIDDLE LAST Author Baer Price, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Cockrill					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW11				16b. SOCIAL SECURITY NO. 215-12-7847		17. INFORMANT ADDRESS Jane Price Barton, 10717 Lakespring Way					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> 410- } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Generalized ASCVD with</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Insufficiency</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>5+ yrs</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.				TITLE (SPECIFY) <u>Deputy</u>				MEDICAL EXAMINER DATE SIGNED <u>3/11/80</u>			
EXAMINER'S NAME (TYPE OR PRINT) Charles F. O'Donnell				ADDRESS 7501 York Road, Towson, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 3-12-80		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.				ADDRESS 1050 York Road		25a. DATE REC'D. BY REGISTRAR MAR 14 1980		25b. REGISTRAR'S SIGNATURE <u>John A. Kennedy</u>			



**IMPORTANT:** If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

24 FUNERAL DIRECTOR  
NAME





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE ISABEL P. LAST PRICE			2a. DATE OF DEATH MONTH DAY YEAR MARCH 24, 1980			2b. HOUR 10:25 A. M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept. 26, 1885		6 AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10 CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney Towson Nursing & Convalescent Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Transit Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 604 Wilton Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST Henry B. Paynter					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rebecca Thompson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-03-8341		17 INFORMANT ADDRESS 167 Rose St. Mrs. Mary L. Schwind Timonium, Md. 21093					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Serulitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Days years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Donald L. Sommerville, MD</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/24/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald L. Sommerville, M.D.					22e. ADDRESS 26 W. Pennsylvania Ave. Towson, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 26, 1980		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto. Co., Md.		
24 FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md.					ADDRESS 6500 York Rd.		25. DATE REC'D. BY REGISTRAR MAR 28 1980		
					26. REGISTRAR'S SIGNATURE <u>Robert M. ...</u>				

14

Female	White	Sept. 25, 1982	24
Maryland	USA		
TOYOTA	Black	1981	24
Maryland	Baltimore	Towson	24
Henry H. Fayner			
216-03-8341	Mr. Jack L. Schmitt	1000	24

Smith

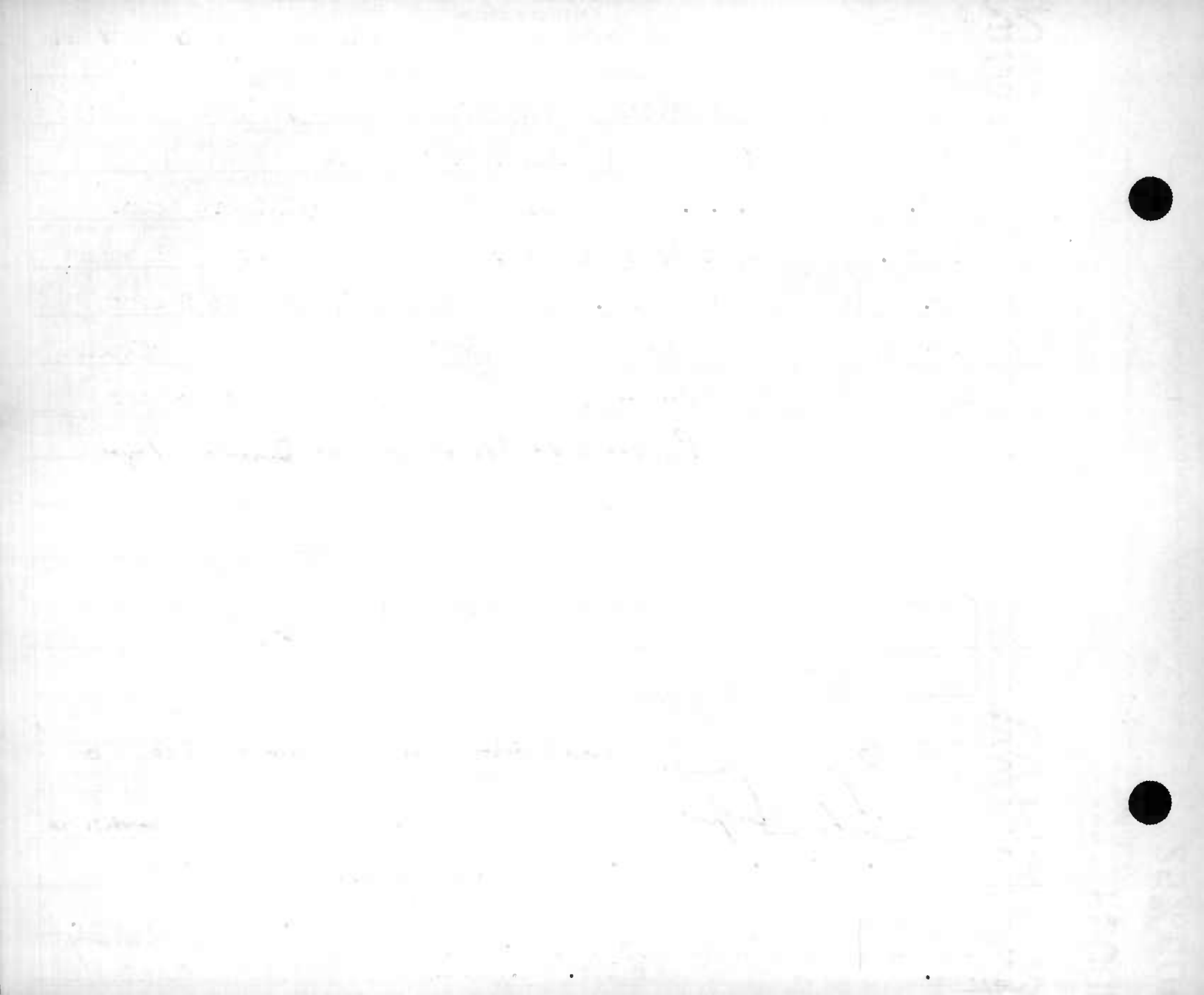
Donald L. Somerville, N.D.  
March 23, 1980  
6300 York Rd.  
Fitchell-Fiedelsa Road, Inc. 216-03-8341

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR			REG. NO. 80 06174								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MARY			MIDDLE CATHERINE			LAST PROCTOR		
2. DATE OF DEATH			MONTH March			DAY 30			YEAR 1980		
2b. HOUR			9:35			P					
3. SEX			Female			4. RACE			White		
5. DATE OF BIRTH			MONTH March			DAY 26			YEAR 1898		
6. AGE (IN YEARS LAST BIRTHDAY)			82			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			Md.		
8. CITIZEN OF WHAT COUNTRY?			U.S.A.			9. BALTIMORE CITY OR COUNTY OF DEATH			Baltimore County MD.		
10. CITY OR TOWN OF DEATH			Balto.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			2901 Alvarado Square		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			Seamstress			12b. KIND OF BUSINESS OR INDUSTRY			Clothing		
13a. STATE			Md.			13b. COUNTY			Balto.		
14. FATHER'S NAME			FIRST Joseph			MIDDLE			LAST King		
15. MOTHER'S MAIDEN NAME			FIRST Sarah			MIDDLE			LAST Hilton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			no			16b. SOCIAL SECURITY NO.			212-09-8937		
17. INFORMANT			Ruth Dorf (niece)			ADDRESS			same address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Progressive Cerebrovascular Disease</u> 4379 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>about 6:30 p.m.</u> , 19 <u>79</u> , to <u>March 30</u> , 19 <u>80</u> , that (we) lost saw the deceased give on <u>March 28</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (li) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dr. Luke E. Terry Jr.</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED March 31, 1980		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Luke E. Terry Jr.			22e. ADDRESS Hampton Plaza - B Level 300 E. Joppa Road								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/3/80			23c. NAME OF CEMETERY OR CREMATORY Oak Lawn			23d. LOCATION CITY OR TOWN Balto. COUNTY STATE Md.		
24. FUNERAL DIRECTOR Schwartz Funeral Home Inc.			24b. ADDRESS 3331 Brehms Lane Balto. Md. 21215			25. DATE REC'D. BY REGISTRAR APR 1 1980			26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 006175					
1. DECEASED NAME (TYPE OR PRINT) CATHERINE Magdalene PROSSER					2a. DATE OF DEATH MONTH DAY YEAR MARCH 6, 1980			2b. HOUR 5:30 a.m.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 17 1900		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 79		IF UNDER 1 YEAR IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.				
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson		12b. KIND OF BUSINESS OR INDUSTRY Bakery		
13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Fullerton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Prosser					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Ritterich					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 219-30-99864		17. INFORMANT ADDRESS Margaret M. Prosser 4414 Ridge Road			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4292 } DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease (c) Parkinson's disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Large sacral decubitus ulcer										
19a. DATE OF OPERATION Feb. 18, 1980			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Sacral decubitus ulcer			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 19, 1980, to March 6, 1980, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 6, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.										
22b. SIGNATURE Baltasar B. Velez, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED March 6, 1980		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Baltasar B. Velez, M.D.						22e. ADDRESS 9515 Harford Road, Baltimore, MD 21234				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/10/80		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home					ADDRESS 7401 Belair Road		DATE REC'D. BY REGISTRAR (25) REGISTRAR'S SIGNATURE MAR 11 1980			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0006177	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Barbara H. Rader</b>							2a. DATE OF DEATH MONTH DAY YEAR <b>March 1st 1980</b>			2b. HOUR A <b>10:30 M</b>	
3. SEX <b>femALe</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 18 1891</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Josephs Hospital</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>at home</b>			12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MD</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Timonium</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>38 Belfast Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Hurka</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine Prazek</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>					16b. SOCIAL SECURITY NO. <b>214 74 1813</b>		17. INFORMANT ADDRESS <b>family records</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meninge Arterio-venous Bleeding</b> <b>5789</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4-8 hrs</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/28</b> , 19 <b>80</b> , to <b>3/1</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>3/1</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Francis T Daly MD</b>				DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/1/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FRANCIS T DALY</b>				22e. ADDRESS <b>4300 N. CHARLES ST.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>				23b. DATE <b>3/4/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. County, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>C. F. EVANS</b>						ADDRESS <b>8800 Harford Rd.</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 7 1980</b>		
									25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

BP



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DHMH - 17  
(VR A15 ME (1))  
15M7/77

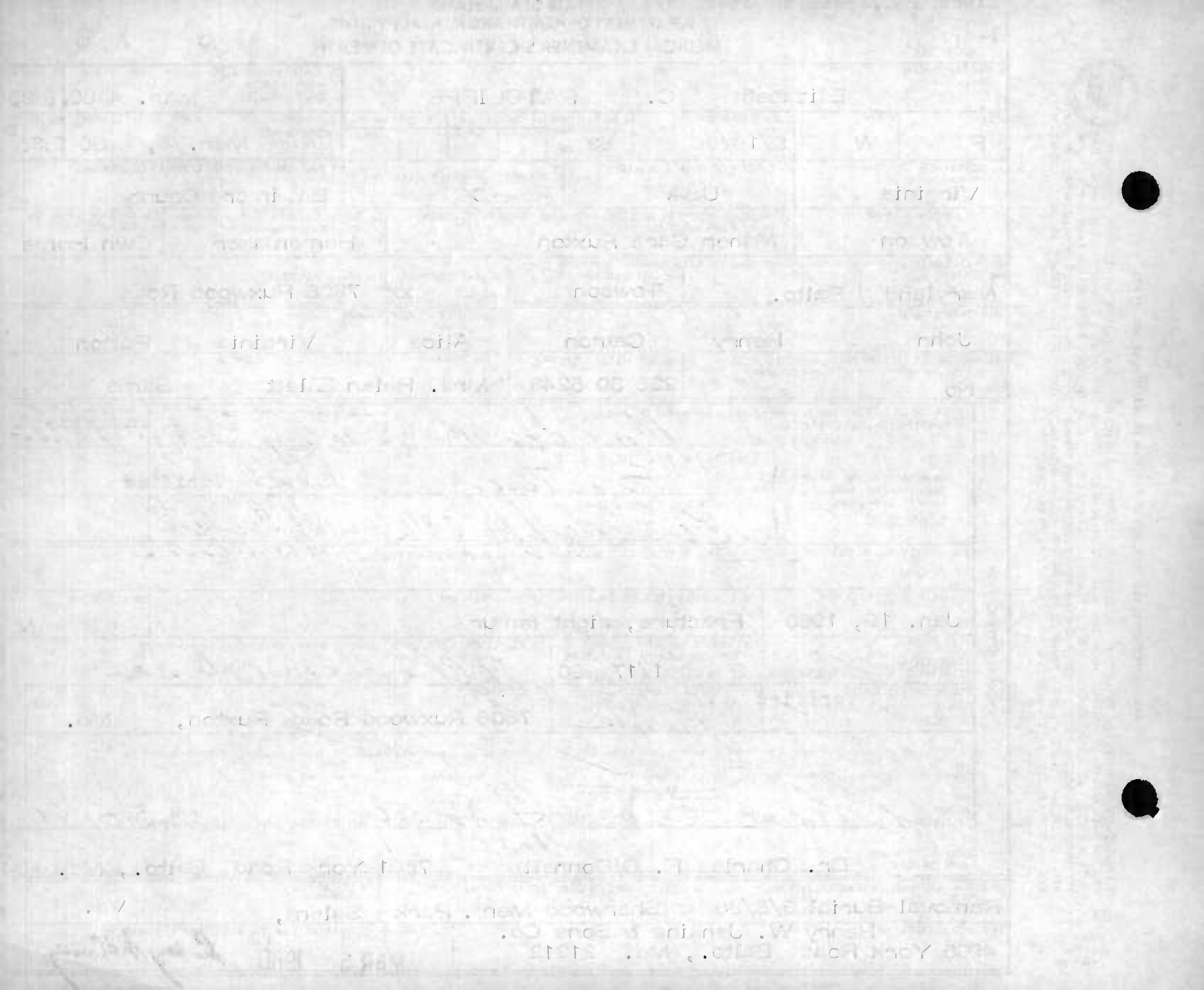
MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06178	
1. DECEASED NAME (TYPE OR PRINT) Elizabeth C. RATCLIFFE										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 9:35 PM Mar. 4, 1980	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 5/19/96	6. AGE (IN YEARS) LAST BIRTHDAY 83 YRS.	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Mar. 4, 1980	2d. HOUR 9:35 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Ruxton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland			13b. COUNTY Balto.		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7806 Ruxwood Road		
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Catron					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Virginia Patton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 226 50 5243		17. INFORMANT Mrs. Helen Ellett			ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 888- IMMEDIATE CAUSE (a) <u>Cardiac-Respiratory Failure</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <u>Fractured Hip</u> Verified DUE TO, OR AS A CONSEQUENCE OF (b) <u>Fractured Hip</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Fractured Hip</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Fractured Hip</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
19a. DATE OF OPERATION Jan. 19, 1980			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture, right femur						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3 P.M. 1/17 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Fell on curb Home</u>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Home</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7806 Ruxwood Road Ruxton, Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>			TITLE (SPECIFY) <u>Deputy</u> MEDICAL EXAMINER						DATE SIGNED <u>3/5/80</u>		
EXAMINER'S NAME (TYPE OR PRINT) Dr. Charles F. O'Donnell			ADDRESS 7501 York Road Balto., Md. #04								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal-Burial			23b. DATE 3/5/80		23c. NAME OF CEMETERY OR CREMATORY Sherwood Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Salem, Va.				
24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212					25a. DATE REC'D. BY REGISTRAR MAR 5 1980		25b. REGISTRAR'S SIGNATURE <u>Henry W. Jenkins</u>				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT SHOULD BE EXECUTED WITHIN 72 HOURS. IT SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

TO MEDICAL EXAMINER: WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

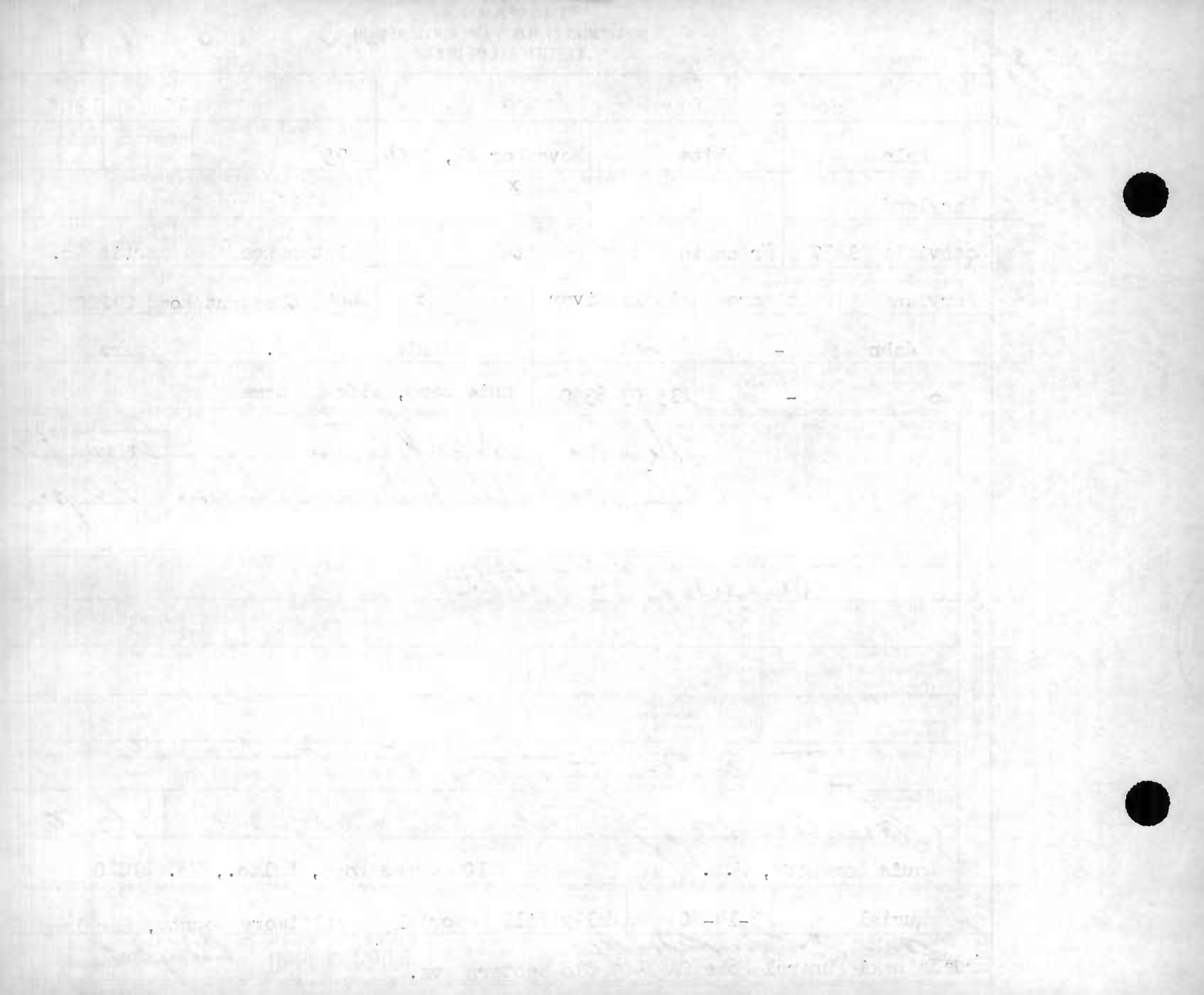
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George Edward REED			2a. DATE OF DEATH MONTH DAY YEAR 3 11 80			2b. HOUR a 1:05 M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 21, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD				
10. CITY OR TOWN OF DEATH Rossville 21237		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Martin Co.		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4048 Chestnut Road 21220	
14. FATHER'S NAME FIRST MIDDLE LAST John - Reed			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie E. Myers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT Annie Reed, wife		ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO OR AS A CONSEQUENCE OF (b) Chronic atherosclerotic disease DUE TO OR AS A CONSEQUENCE OF (c) 10 yrs 410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from Aug 19 87, to March 12 19 80, that (I) (we) last saw the deceased alive on March 12 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE Louis Semenoff, M.D.			DEGREE M.D.			22c. DATE SIGNED 3/12/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis Semenoff, M.D.			22e. ADDRESS 2108 Orem Road, Balto., Md. 21220							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-14-80		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Maryland			
24. FUNERAL DIRECTOR Brodzinski Funeral Home			25a. DATE REC'D. BY REGISTRAR MAR 13 1980			25b. REGISTRAR'S SIGNATURE [Signature]				





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DHMH - 17  
(V.R. 15 ME (5))  
15M/7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 06180

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Wennelle P. Reeves			2a. DATE KNOWN OF DEATH ESTIMATED MONTH 3 DAY 1 YEAR 1980			2b. HOUR M 1:10		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH 6 DAY 12 YEAR 47	6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH 3 DAY 1 YEAR 1980	7d. HOUR a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.		
10. CITY OR TOWN OF DEATH PerryHall		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BelAir Rd north of Miller Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto. Mechanic		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Whiteford	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Box 184
14. FATHER'S NAME FIRST MIDDLE LAST Zelmo Warren Reeves Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Ruff					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Vietnam		17. INFORMANT Father		ADDRESS Box 184 Whiteford, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:55pm 3 1 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/auto impact			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE BelAir Rd. n. of Miller Rd, PerryHall, Balto, MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural cause <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Thomas D. Smith			TITLE (SPECIFY) Deputy Chief			DATE SIGNED 3/1/80		
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn St.			BALTO., MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-6-80		23c. NAME OF CEMETERY OR CREMATORY Clarks Chapel		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Arnold W. Beard			ADDRESS Funeral Ser. 117 Cecil Ave.			25a. DATE REC'D. BY REGISTRAR MAR 4 1980		25b. REGISTRAR'S SIGNATURE History McCreedy



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8006181	
1. DECEASED NAME (TYPE OR PRINT) RAYMOND FRANK REID			2a. DATE OF DEATH MONTH DAY YEAR 03 31 80			2b. HOUR 3:30 P.M.					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 07 31 18		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5480 ADDINGTON ROAD				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER (MOVER)		12b. KIND OF BUSINESS OR INDUSTRY MOVING			
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5480 ADDINGTON ROAD, 21229			
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE W. REID				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGUERITE MARGISON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT MARIE J. REID		17. ADDRESS 5480 ADDINGTON ROAD, 21229					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>1541</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>Anemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic renal carcinoma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>2 wks.</u> <u>1 yr.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>William C. Waterfield</u>				DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/1/80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM C. WATERFIELD, M.D.				22e. ADDRESS ST. AGNES HOSPITAL, 900 S. CATON AVENUE							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 04-03-80		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MARYLAND					
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 21229 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR APR 02 1980		25b. REGISTRAR'S SIGNATURE <u>Anthony M. Brady</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Francis J. Reimers</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 15, 1980</b>			2b. HOUR <b>1:55P M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>September 20, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Belair</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>523 Idlewild Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Kujawa</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine Wladarek</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-26-7186</b>		17. INFORMANT ADDRESS <b>Elsworth J. Frederick 523 Idlewild Rd. Belair</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe COPD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i> M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>Mar 17, 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Vijay Nair, M.D.</b>					22e. ADDRESS <b>1710 A Harford Road Fallston, Md/</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Mar 19, 80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cem PNC</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Doppel Brothers, Inc. 7110 Belair Road 21206</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		





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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06183			
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward Franklin Reynolds										ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 27 1980		9:25 AM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 5 11 27		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 52		IF UNDER 1 YR. MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 27 1980		7d. HOUR 9:25 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10. CITY OR TOWN OF DEATH Randallstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3933 Carthage Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed				12b. KIND OF BUSINESS OR INDUSTRY Painter	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3933 Carthage Road					
14. FATHER'S NAME FIRST MIDDLE LAST Milton Reynolds						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther A. Kalb							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II				16b. SOCIAL SECURITY NO. 219-22-3335		17. INFORMANT ADDRESS Marshall K. Reynolds MD 21061 1010 7th St. Point Pleasant, Glen Burnie,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 2749 IMMEDIATE CAUSE (a) <u>Acute M. U.</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Arteriosclerotic Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sout.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 100127			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Lester N. Kolman				TITLE (SPECIFY) Deputy				DATE SIGNED 3/27/80					
EXAMINER'S NAME (TYPE OR PRINT) LESTER N. KOLMAN, M.D.				ADDRESS 6821 Reisterstown Rd/									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 3/29/80		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Baltimore MD					
24. FUNERAL DIRECTOR LORING BYERS FUNERAL DIRECTORS, P.A. 8728 Liberty Rd., Randallstown, MD 21133						25a. DATE REC'D. BY REGISTRAR MAR 28 1980		25b. REGISTRAR'S SIGNATURE [Signature]					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 80 06184			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 03 28 80			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY KENNEDY C. RICE				2b. HOUR 6:40P M			
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAR. 3 1898		6 AGE (IN YEARS (LAST BIRTHDAY)) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH TOWSON MD.	
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N. CHARLES STREET		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN RUXTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST RICHARD CROMWELL		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVELYN B. MICHEL		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS JOHN H. RICE JR. BALTO., MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1533 RECURRENT CARCINOMA OF SIGMOID COLON DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. DATE SIGNED 03/28/80	
22b. I certify that (I) (this hospital) attended the deceased from 03/28 1980 to 03/28 1980, that (I) (we) lost the deceased above, (I) (we) (did) (did not) view the body after death.				22c. DATE SIGNED 03/28/80			
22b. SIGNATURE [Signature] DEGREE				22c. DATE SIGNED 03/28/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. S.P. GIRDHAR				22e. ADDRESS GREATER BALTIMORE MEDICAL CENTER			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-31-80		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24 FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co., Balto., Md.				25. DATE REC'D. BY REGISTRAR MAR 31 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

03/26/60

KELLEY, J. C.

WHITE

1020

2701 N. CHARLES STREET

BALTIMORE

WHITE

CHAMBERLAIN

WHITE

JOHN H. KISS JR.

WHITE

DEPARTMENT OF SOCIAL SERVICES

03/26/60

03/26/60

03/26/60

03/26/60

GREAT BALTIMORE MEDICAL CENTER

DR. S. P. [illegible]

1-31-60

Henry A. Jenkins & Sons Co., Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 0 6 1 8 5			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Kenneth W. RICKER SR.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>March 6, 1980</b>			
3. SEX <b>M</b>				2b. HOUR <b>8:45P. M</b>			
4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 26 14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>ESSEX</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQ. HOSP</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CIRCUIT COURT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
13a. STATE <b>MD.</b>				13b. COUNTY <b>BALTO</b>			
13c. CITY OR TOWN <b>ESSEX</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>WALTER G. RICKER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HENRIETTA —</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO <b>215-10-0350</b>			
17. INFORMANT ADDRESS <b>LEE RICKER ABOVE</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410 - Cardio-Pulmonary Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Probable Myocardial Infarction</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 4, 1980</b> to <b>March 6, 1980</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 6, 1980</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/6/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm SUAREZ</b>				22e. ADDRESS <b>9000 Franklin Sq. Dr., Balto., MD 21237</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/10/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SARVED HEARTS OF JESUS</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>CONNELLY F.H. 300 INACE Ave</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

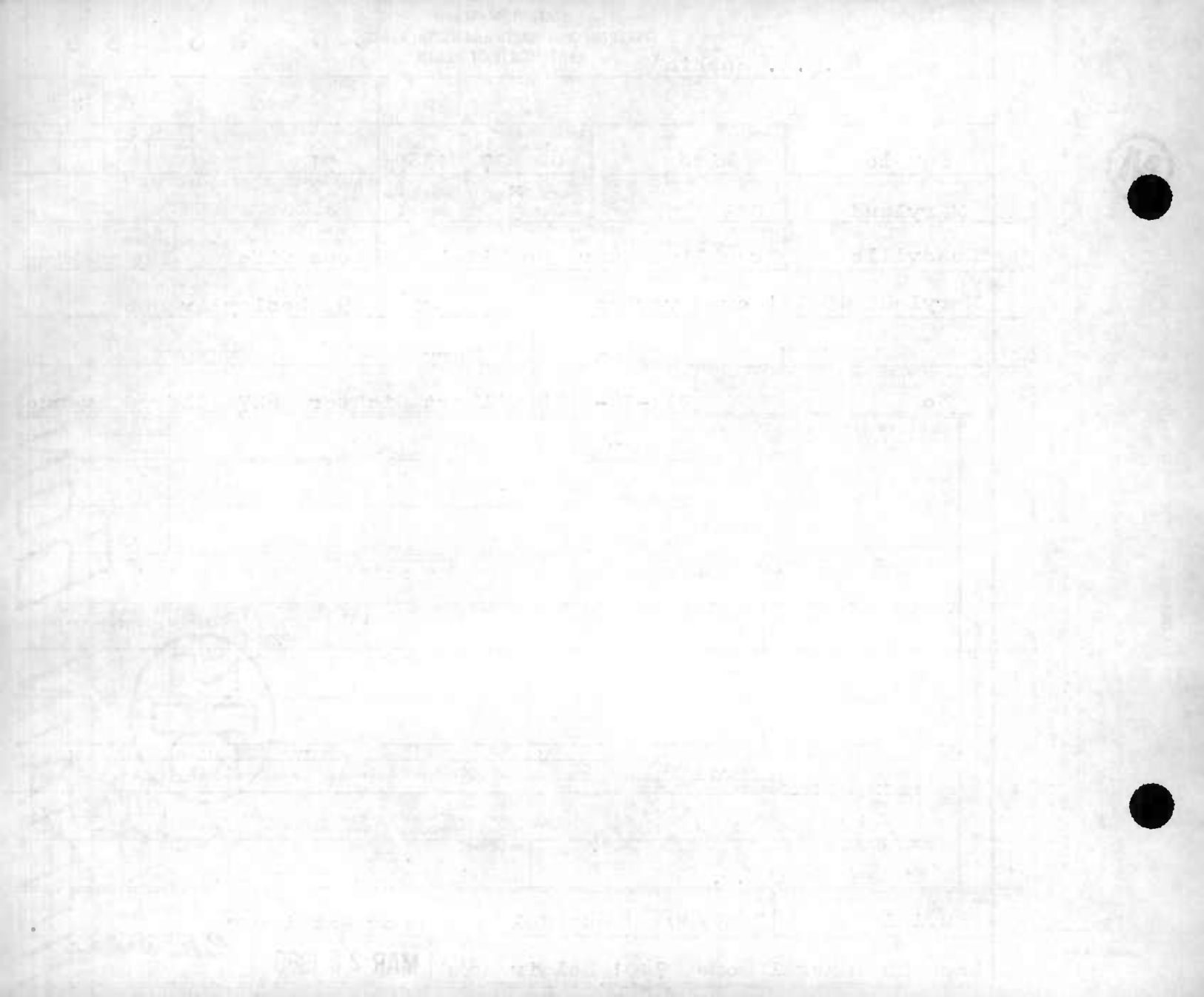


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 0 0 6 1 8 6	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Sophie RICKTER		2a. DATE OF DEATH MONTH DAY YEAR March 22, 1980	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 27 1889	
6 AGE (IN YEARS LAST BIRTHDAY) 91		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		10 CITY OR TOWN OF DEATH Rossville	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaking	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Overlea	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9 Chesley Avenue		14 FATHER'S NAME FIRST MIDDLE LAST UNKNOWN Klima	
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-74-8888	
17 INFORMANT Gilbert Rickter		ADDRESS 827 Mildred Avenue		18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: 5990 IMMEDIATE CAUSE (a) Electrolyte imbalance Digoxin (b) Anemia (c) Protein urinary tract infection	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. certify that <del>xx</del> (this hospital) attended the deceased from March 14, 19 80, to March 22, 19 80, that <del>x</del> (we) lost the deceased alive on March 22, 19 80, and that in <del>xx</del> (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death.		22b. SIGNATURE Michael Koger M.D. DEGREE mb	
22c. DATE SIGNED 3/22/80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Koger M.D.		22e. ADDRESS 9000 Franklin Square Drive	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/25/80		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		24. FUNERAL DIRECTOR NAME Lassahn Funeral Home		25a. DATE REC'D. BY REGISTRAR MAR 28 1980	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S NAME		25d. REGISTRAR'S ADDRESS	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Alberta Pauline Riddick</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>March 29 1980</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 24 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88yrs.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Dundalk, md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>665 N. Avondale</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md.</b> 13b. COUNTY <b>Balto</b> 13c. CITY OR TOWN <b>Balto</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2912 W. Coldspring La.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Bell</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nancy Ann Young</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>079-05-8103</b>		17. INFORMANT ADDRESS <b>David Riddick 2912 W. Coldspring La.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Uremia</b> <b>7169</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTRITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>STYPERENSION</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 4</b> <b>1 8 4 4</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>March 29</b> 19 <b>80</b> , to <b>March 29</b> 19 <b>80</b> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>William C. Wade, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3-29-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William C. Wade, M.D.</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/2/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto Md</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>James Morton &amp; Sons 1701 Laurens St. 21217</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 9 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McBratney</b>	

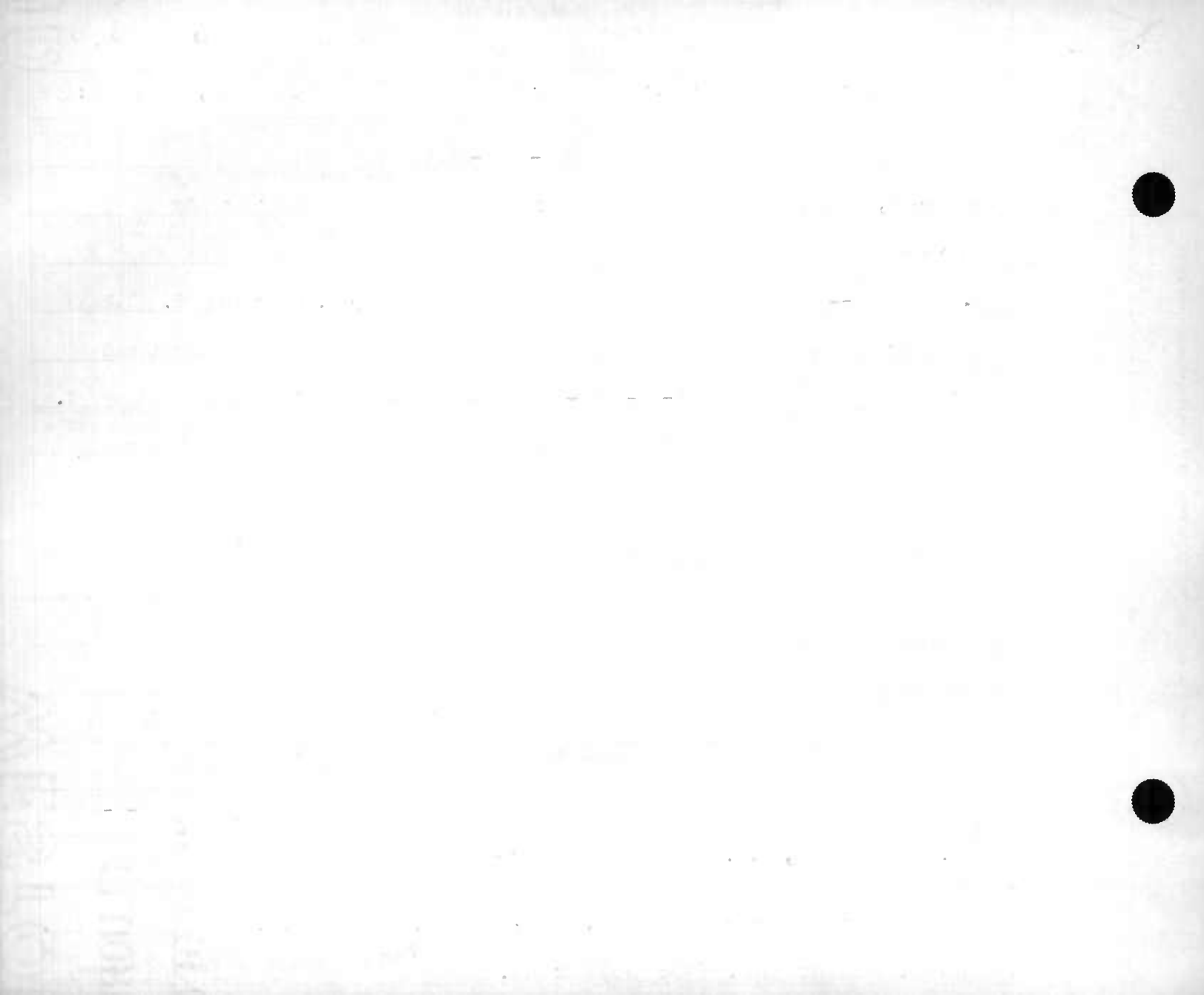
William C. Hodge, M.D.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
Anna Virginia Riley			March		2,		1980		4:15A		M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		Caucasian		9 - 8 - 1892		87 YRS.		MONTHS		DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Baltimore, Maryland		USA				Baltimore County MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		Stella Maris Hospice		Housewife									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md.		--		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		639 S. Conkling St. (21224)					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Edward James Kelly				Anna Virginia Archibald									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No				213-05-7586-D		Stella Maris Hospice		Dulaney Valley Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hours			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>71</u> , to <u>March</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>March</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>E. Lee Robbins</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3-2-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Lee Robbins, M.D.				22e. ADDRESS 1005 York Place									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		3-5-80		Mt. Olivet Cem.		Balto.		Md.					
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John C. Miller Inc.				6415 Belair Rd.				MAR 5 1980		<i>Robert McChesney</i>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR AT 15 ME (5))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

06189

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Joseph Egbert Rinaca</b>			2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> 3 DAY 17 YEAR 1980			2b. HOUR <sup>50</sup> PM		
3. SEX <b>Male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH 12 DAY 3 YEAR 1889	6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH 3 DAY 17 YEAR 1980	7d. HOUR <sup>50</sup> PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Shenandoah Va USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.		
10. CITY OR TOWN OF DEATH <b>Perry Hall Md</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4223 DARNELL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stationary Eng</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>shoe</b>
13a. STATE <b>Md</b>			13b. COUNTY <b>Balto</b>	13c. CITY OR TOWN <b>Perry Hall</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>4223 DARNELL 21236</b>		
14. FATHER'S NAME <b>Phillip</b> MIDDLE LAST				15. MOTHER'S MAIDEN NAME <b>Roberta</b> MIDDLE LAST <b>BATMAN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		(IF YES, GIVE WAR OR DATES) <b>-</b>		16b. SOCIAL SECURITY NO. <b>716105202</b>		17. INFORMANT ADDRESS <b>Marjorie Wagner, daughter, Ave. 21236</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4292 Atherosclerotic Cardiovascular Disease</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>und</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION <b>X</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>John C. Hyle</b>			M.D. <b>JCH</b>			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN C. Hyle</b>			ADDRESS <b>7527 Belair</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/21/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Belair Memorial Gard.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>				ADDRESS <b>3331 Brehms Lane Balto., Md. 21213</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia K. Bundy</b>

MEDICAL CERTIFICATION

4113

9-2-19

405201 AC

24

4

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John (H.) Nash

James D. Reid

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS SUSPECTED, THE FUNERAL DIRECTOR SHOULD BE ADVISED. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. IF THE DEATH OCCURRED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06190	
1. DECEASED NAME (TYPE OR PRINT) <b>PEARL ELIZABETH RITTER</b>										2a. DATE KNOWN OF DEATH ESTI-MATED <b>March 10, 1980</b>										2b. HOUR <b>1:30 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>June</b> DAY <b>22</b> YEAR <b>1906</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>73</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>		2c. DATE PRONOUNCED DEAD <b>March 10, 1980</b>		2d. HOUR <b>1:30 PM</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Co. Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD									
10. CITY OR TOWN OF DEATH <b>Towson</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>G. B. M. C. Hospt.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Black &amp; Decker</b>				12b. KIND OF BUSINESS OR INDUSTRY									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Timonium</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1 Oakway Drive</b>													
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>C.</b> LAST <b>Carlisle</b>										15. MOTHER'S MAIDEN NAME FIRST <b>Annie</b> MIDDLE <b>E.</b> LAST <b>Berry</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>217-14-3299</b>				17. INFORMANT ADDRESS <b>Mr. Robert L. Ritter Timonium Md.</b>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410- Acute Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>Generalized ASCVD</b> (b) <b>Generalized ASCVD</b> (c) <b>5 ± yrs</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>3/10/80</b>				MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT) <b>DR. CHARLES F. O'DONNELL</b>				ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>March 13, 80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jessup Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Cockeysville, Md.</b> COUNTY STATE											
24. FUNERAL DIRECTOR NAME <b>Erlene Funeral Home</b> ADDRESS <b>Reisterstown, Md. 21136</b>										25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Kathy McBratney</b>									



PEARL ELIZABETH RIVER

Aug 2, 1901

1100.00.00

1100.00.00

1100.00.00

1100.00.00

1100.00.00

DR. CHARLES F. COWELL

1100.00.00

1100.00.00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 13 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) HERBERT H. ROBERTSON					2a. DATE OF DEATH MONTH DAY YEAR MARCH 12, 1980			2b. HOUR P 6:10 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 18 01		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.				
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Letter carrier		12b. KIND OF BUSINESS OR INDUSTRY US Mail		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Perry Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Orem					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. 1919-1922		17. INFORMANT ADDRESS Evelyn M. Hearn 4011 Pinedale Drive			
18. CAUSE OF DEATH (Enter only one cause per line for each organ system) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>3989</u> DUE TO, OR AS A CONSEQUENCE OF <u>CONGESTIVE HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>RHEUMATIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>RHD</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 10</u> , 19 <u>80</u> , to <u>MARCH 12</u> , 19 <u>80</u> , that (we) last saw the deceased alive on <u>MARCH 12</u> , 19 <u>80</u> , and that (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Kamal M Jain</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KAMAL M JAIN					22e. ADDRESS 21030 10402 RIDGLAND RD. COCKEYSVILLE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/15/80		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Baltimore Md.				
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home					ADDRESS 7401 Belair Road		25a. DATE REC'D. BY REGISTRAR MAR 13 1980		25b. REGISTRAR'S SIGNATURE <u>Dorothy McCreedy</u>	

MEDICAL CERTIFICATION

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4114

SECRET

OFFICE OF THE SECRETARY OF DEFENSE  
WASHINGTON, D.C. 20301

MARCH 10, 1980

THE SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

OFFICE OF THE SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

OFFICE OF THE SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

MARCH 10, 1980

WASHINGTON, D.C. 20301

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WASHINGTON, D.C. 20301

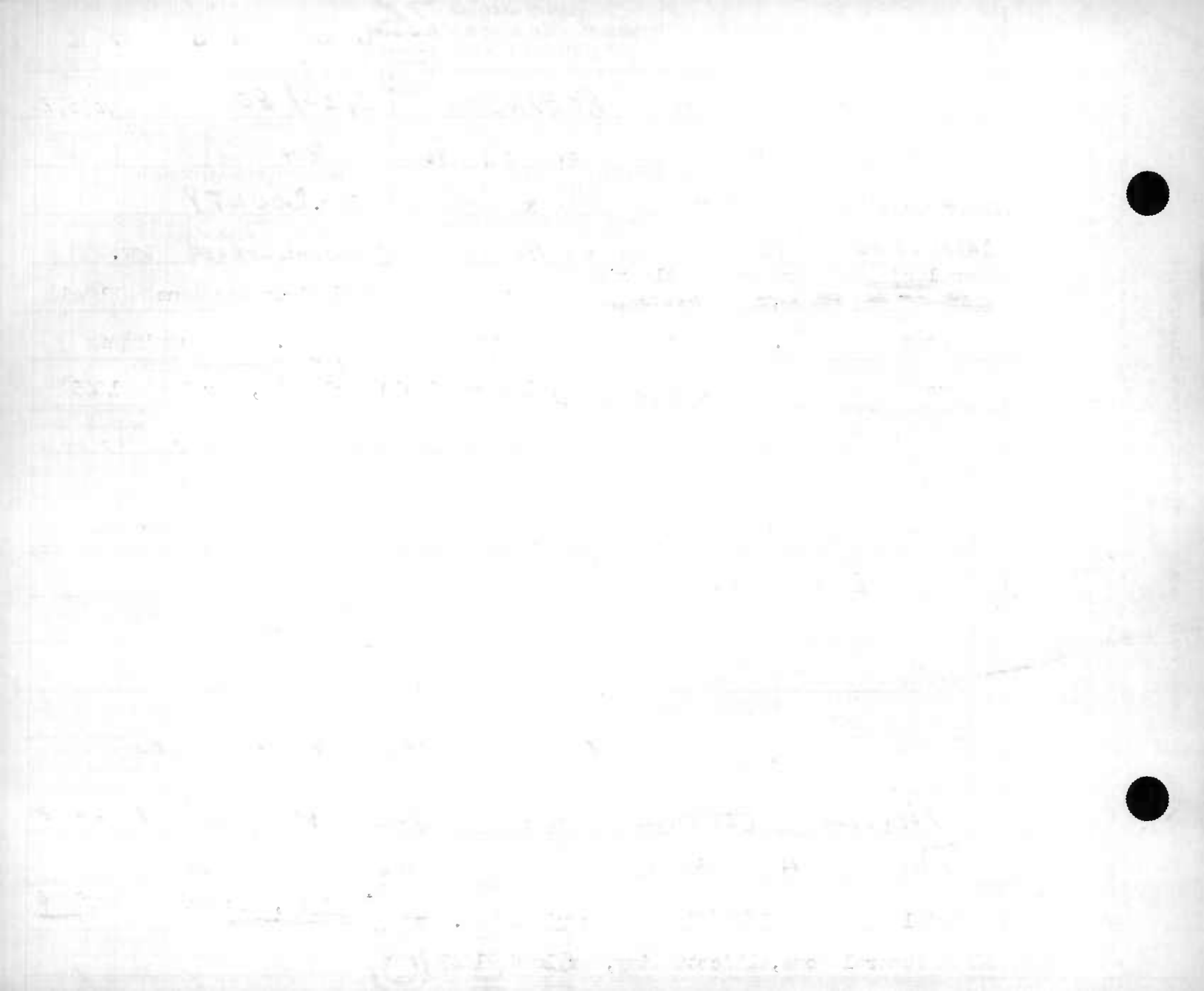
WASHINGTON, D.C. 20301

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 006192						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
JOSEPHINE A. ROBINSON						3/22/80			10:57 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR IF UNDER 24 HRS	
FEMALE		WHITE		01 09 96		84 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
WASHINGTON, D.C.		U.S.				Balto. COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CATONSVILLE		TAWES NURSING HOME				CLERICAL WORKER		Gov.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
BALTIMORE		BALTO.		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9495 Timesweep Lane (21045)	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
John H. Steep			Maude L. Cunningham						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
no			577-05-5455-D			9495 Timesweep Lane Eleanor Finnin Columbia, Maryland 21045			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Generalized Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 min.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Intoxication</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1</u> 19 <u>79</u> , to <u>3-22</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3-21-80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
<u>Thomas A. Pittman</u>				M.D.				3-22-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Thomas A. Pittman				5651 Harpers Fm Rd.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY	
burial		3/26/80		Meadowridge Mem. Park		Ellicott, Howard		Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SLACK Funeral Home, Ellicott City, Maryland 21043				MAR 27 1980		<u>Henry McBrady</u>			

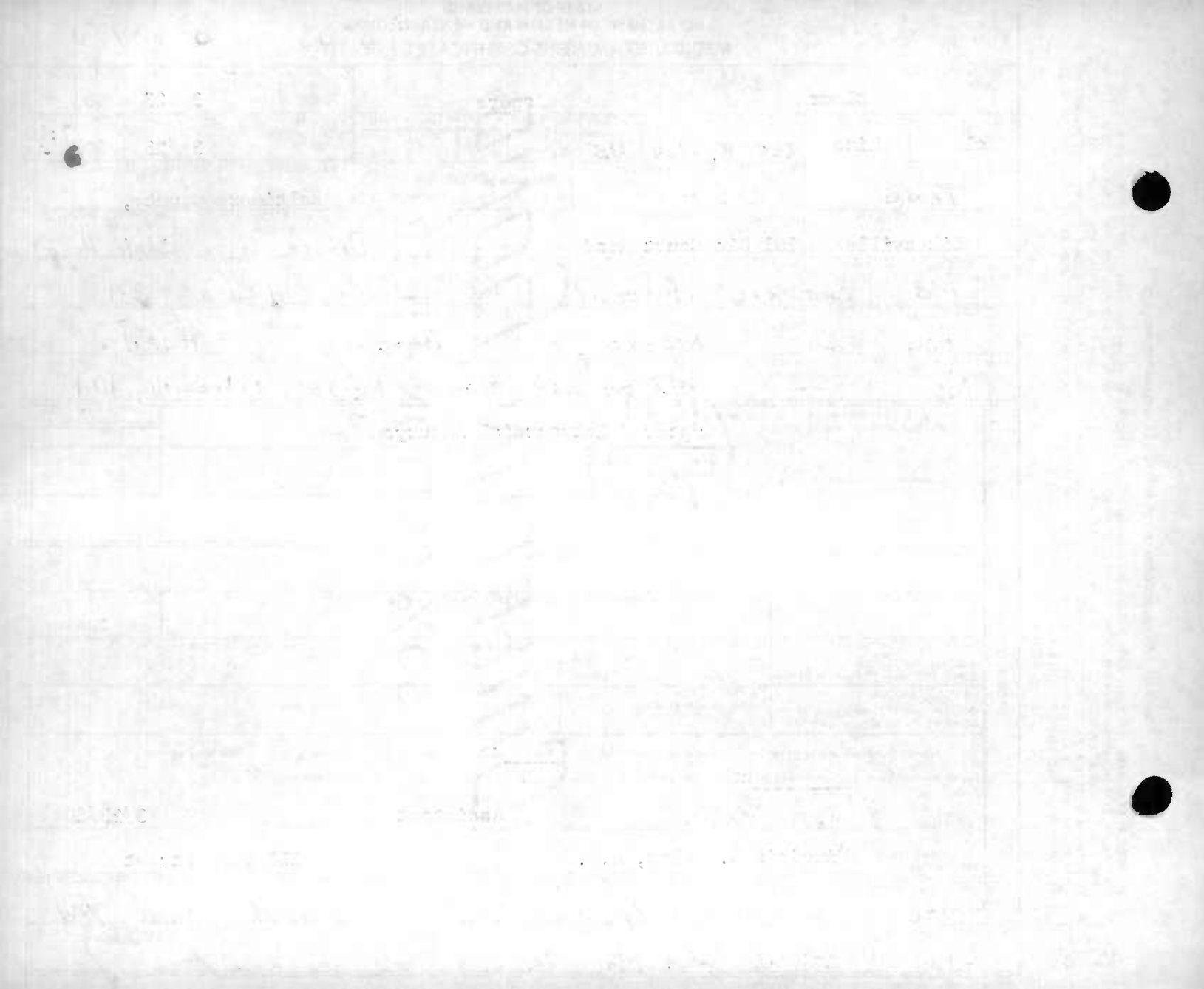


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMM - 17  
(VR A15 ME (S))  
30M 7/73

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				06193 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Elmer Rogers</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>3 23 19 80</b>						2b. HOUR <b>M</b>							
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 8, 1934</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>45</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN <b>45</b>		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN <b>45</b>		2c. DATE PRONOUNCED DEAD <b>3 23 19 80</b>		2d. HOUR <b>7:10 A.M.</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tenn.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>							
10. CITY OR TOWN OF DEATH <b>Pikesville</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>101 Old Court Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Driver</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>State Hospital</b>							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE <b>Md.</b>				13b. COUNTY <b>Baltimore</b>				13c. CITY OR TOWN <b>Pikesville</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>101 Old Court Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Roy D. Rogers</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Hurd</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>410 54 6669</b>				17. INFORMANT <b>Maggie Rogers</b>				ADDRESS <b>Pikesville, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Ruptured Intracranial Aneurysm</b> <b>430-</b> IMMEDIATE CAUSE (a) } Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) } (c) }												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>				TITLE (SPECIFY) <b>Assistant</b>				MEDICAL EXAMINER				DATE SIGNED <b>3/23/80</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn Street</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>3-27-80</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Springfield Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Carroll Md.</b>							
24. FUNERAL DIRECTOR NAME <b>Harry W. Haight</b>				ADDRESS <b>Lysanville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1980</b>				25b. REGISTRAR'S SIGNATURE <b>Harry W. Haight</b>							

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 006194			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ADOLPH G. ROMETSCH				2a. DATE OF DEATH MONTH DAY YEAR MARCH 5, 1980				2b. HOUR 8:28 AM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Oct. 7, 1896		6 AGE (IN YEARS LAST BIRTHDAY) 83		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7d. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10 CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH'S HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor-		12b. KIND OF BUSINESS OR INDUSTRY Flynn Emrich			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3330 Woodside Ave.			
14 FATHER'S NAME FIRST MIDDLE LAST Adolph F. Rometsch		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fredia Gerstner		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW 1 215-09-3015		17 INFORMANT ADDRESS Mrs. Elizabeth I. Lerch Same as 13e	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4380 CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from FEBRUARY 16, 19 80, to MARCH 5, 1980, that (we) last saw the deceased alive on MARCH 5, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.											
22b. SIGNATURE Lester A. Wall				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3/5/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LESTER A. WALL, M.D.				22e. ADDRESS 7620 YORK RD. TOWSON, MD. 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE March 8, 1980		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24 FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR MAR 6 1980		25b. REGISTRAR'S SIGNATURE [Signature]			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PAULINE		MIDDLE ROSEBORD		LAST ROSEBORD		2a. DATE OF DEATH MONTH DAY YEAR 3-23-80		2b. HOUR 1:45AM M	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 2 25 37		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1836 E. Fayette Street	
14. FATHER'S NAME FIRST MIDDLE LAST George Thompson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bernice Lightner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-34-7110		17. INFORMANT ADDRESS Theodore Roseboro 1836 E. Fayette St.					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFR. INFARCTION/ARRHYTHMIA 410- DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3-23 19 80, to 3-23 19 80, that (I) (we) last saw the deceased alive on 3-23 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DR. KNAUER-MD				DEGREE				22c. DATE SIGNED 3-23-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Knut Knaue M.D.				22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/27/80		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR MAR 26 1980		25b. REGISTRAR'S SIGNATURE Rafaela Knaue	

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MAR 8 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		3. DECEASED NAME		4. DATE OF BIRTH		5. BALTIMORE CITY OR COUNTY OF DEATH	
1b. DECEASED NAME (TYPE OR PRINT)		2b. MONTH DAY YEAR		3a. FIRST MIDDLE LAST		4a. MONTH DAY YEAR		5a. CITY OR COUNTY	
EMILY Wylie RUSSELL		3 25 80		10 AM		6 24 88		COUNTY	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
FEMALE		CAUCASIAN		6 24 88		91 YRS		COUNTY	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. BALTIMORE CITY OR COUNTY OF DEATH	
GLASGOW Scotland		U. S. A.				COUNTY		COUNTY	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. BALTIMORE CITY OR COUNTY OF DEATH	
TOWSON		MANOR CARE RUXTON		Homemaker		---		COUNTY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Balto.		Timonium		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2314 Eastridge Rd., Timonium Md.	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
John Wylie		Janet Pattison		No		282-10-5248		Timonium	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
PART I. DEATH WAS CAUSED BY:						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
IMMEDIATE CAUSE (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4292								± 5 YRS	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE	
		P.M. 19				JAN 28 19 80		E. P. Costlow MD	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22c. DATE SIGNED		3 25 80	
						3 25 80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. NAME OF CEMETERY OR CREMATORY		23b. LOCATION CITY OR TOWN COUNTY STATE		23c. DATE REC'D. BY REGISTRAR	
E. P. Costlow MD		3501 ST PAUL ST 144 BALT MD 21218		Brooklyn Hgts Cem.		Cleveland Cuyahoga Ohio		MAR 27 1980	
23d. BURIAL, CREMATION, REMOVAL (SPECIFY)		23e. DATE		23f. NAME OF CEMETERY OR CREMATORY		23g. LOCATION CITY OR TOWN COUNTY STATE		23h. DATE REC'D. BY REGISTRAR	
Burial		3/28/80		Brooklyn Hgts Cem.		Cleveland Cuyahoga Ohio		MAR 27 1980	
24 FUNERAL DIRECTOR'S NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR	
J. E. Lowell Lemmon		10 W. Padonia Rd.		MAR 27 1980		D. J. Kelly		MAR 27 1980	

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Page 7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH				REG. NO. 80 06197			
1. DECEASED NAME (TYPE OR PRINT) MARY L. RUSSELL					2a. DATE OF DEATH MONTH DAY YEAR 03 07 80			2b. HOUR 9:10 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 1, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TOWSON Baltimore County MD.			
10. CITY OR TOWN OF DEATH Towson BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 N. CHARLES STREET GBMC				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nursing	
13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Russell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Loretta Darraugh				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 218-07-7650		17. INFORMANT Pickersgill			ADDRESS 615 Chestnut Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA RIGHT LUNG DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 02/27 19 80, to 03/07 19 80, that (I) (we) lost saw the deceased alive on 03/07 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Anthony Vetere MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 03/07/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ANTHONY VETERE				22e. ADDRESS GREATER BALTIMORE MEDICAL CENTER					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 11, 1980		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.				ADDRESS 1050 York Road Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR MAR 11 1980		25b. REGISTRAR'S SIGNATURE Anthony Vetere	





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WUSSELL

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WUSSELL

YOUNG

201 N. CHARLES STREET

BALTIMORE

11 CHARLES ST.

11 CHARLES ST.

11 CHARLES ST.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

006198

1- FOR  
STATE  
REGISTRAR

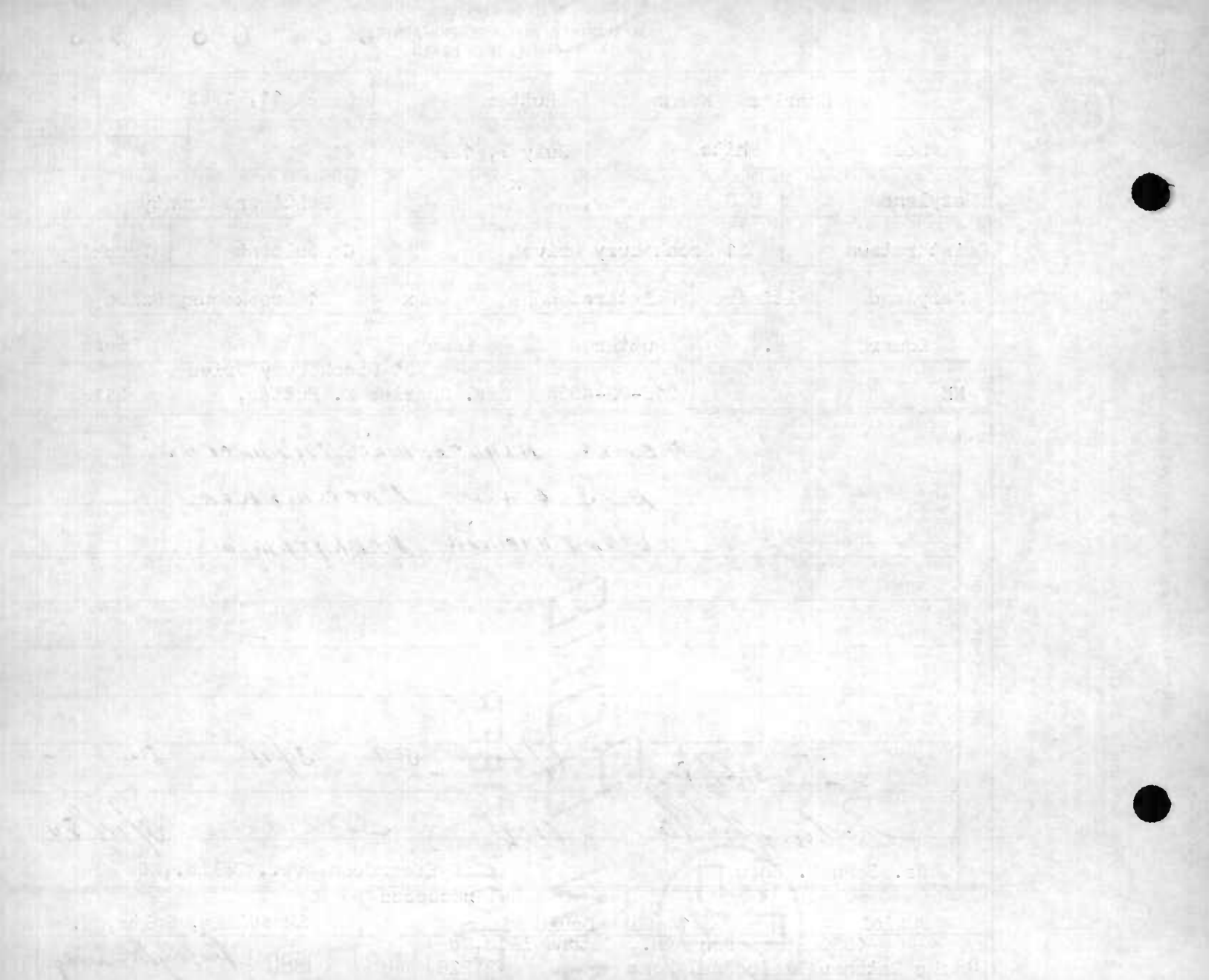
1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
Charles Keene Rutter					March 11, 1980				M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 74 HRS		
Male	White	July 7, 1898		81	MONTHS		DAYS		HOURS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U S A			Baltimore County				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Reisterstown		31 Brookebury Drive			Consultant		Trucking		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d INSIDE CITY LIMITS?		13e STREET ADDRESS		
13a STATE					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		31 Brookebury Drive		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST Edward L. Rutter					FIRST MIDDLE LAST Emma Reese				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		31 Brookebury Drive			
NO		215-03-4664		Mrs. Charles K. Rutter,		21136			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>									
410- DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) <u>A.S.E.V.D. PRE-EXISTING</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>VENTRICULAR ARRHYTHMIA</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (the hospital) attended the deceased from <u>1/1</u> , 19 <u>57</u> , to <u>3/11</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>3/6/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
<u>John H. Shaw</u>		<u>M.D.</u>					<u>3/11/80</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Dr. John H. Shaw		5800 Edmondson Ave., Balto., Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATOR		23d. LOCATION CITY OR TOWN			
Burial		3/14/80		Druid Ridge		Pikesville, Balto., Md.			
24. FUNERAL DIRECTOR'S NAME		1630 Edmondson Ave., Catonsville, Md		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Witzke Catonsville Funeral Home		21228		MAR 14 1980		<u>Anthony McCreedy</u>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

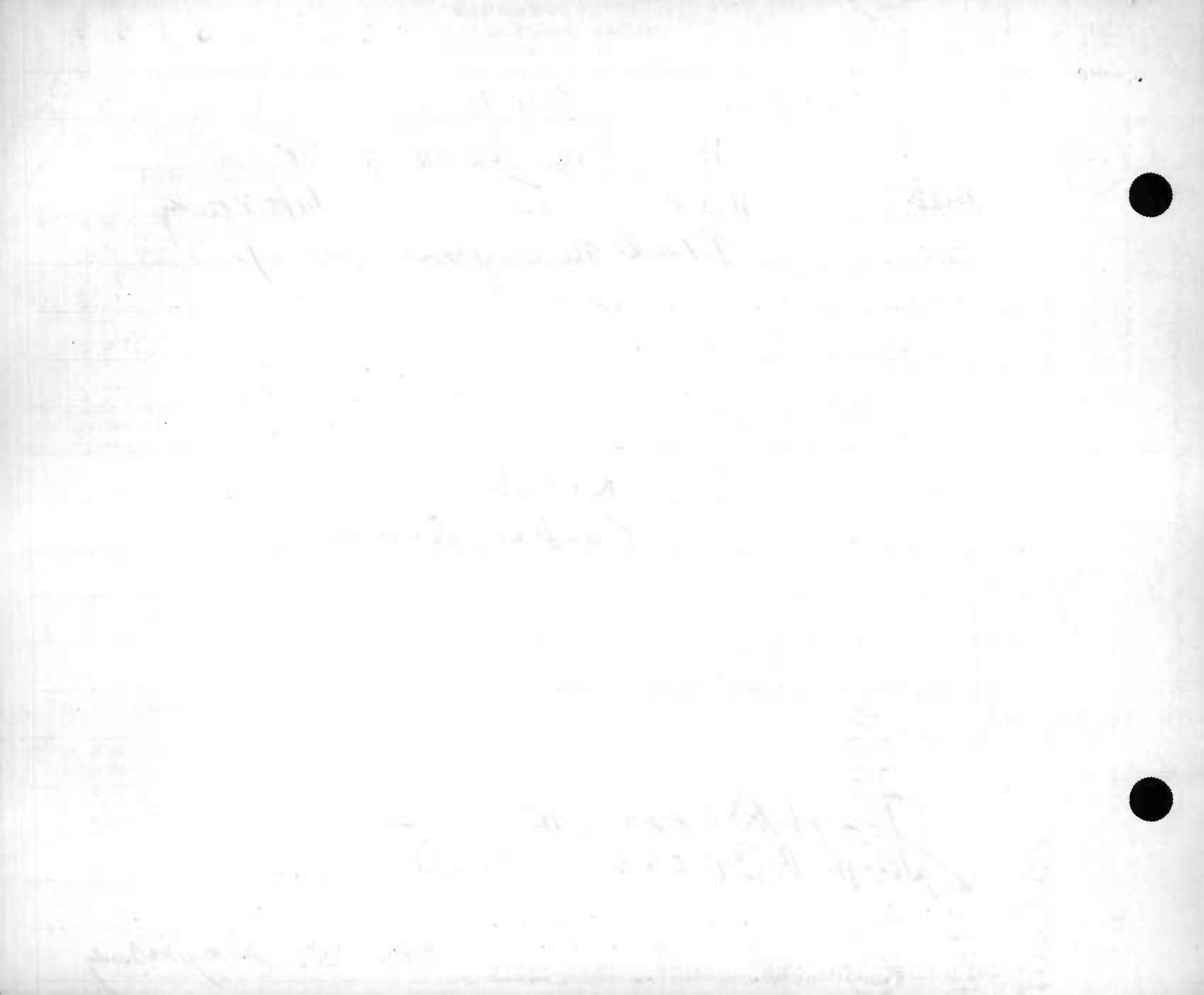
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>LEAH</b>		FIRST <b>SACHS</b>		LAST <b>SACHS</b>		2a DATE OF DEATH MONTH DAY YEAR <b>3 10 80</b>		2b HOUR <b>5 50 PM</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>1 12 23 01</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10 CITY OR TOWN OF DEATH <b>PIKESVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DeWitt Nursing Home</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MARYLAND</b>		13b COUNTY <b>BALTO.</b>		13c CITY OR TOWN <b>RANDALLSTOWN</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>3802 COLLIER RD. #21133</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>ABRAHAM SALTZMAN</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SARAH NADITCH</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>213-30-5015D</b>		17 INFORMANT <b>MRS. GERTRUDE FRIEDMAN</b> <b>3802 COLLIER RD. RANDALLSTOWN, MD 21133</b>					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2500</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Heart attack</b>		DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiac Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	---	--	--	--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Joseph B Gross</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>3/10/80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph B Gross</b>		22e ADDRESS <b>600 Reisterstown</b>					

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>MAR. 12, 1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>KOVNA CONG.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO. MD</b>	
24 FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>		25a DATE REC'D BY REGISTRAR <b>MAR 18 1980</b>		25b REGISTRAR'S SIGNATURE <b>Robert H. Brady</b>			
6010 REISTERSTOWN RD. BALTO., MD		21215					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

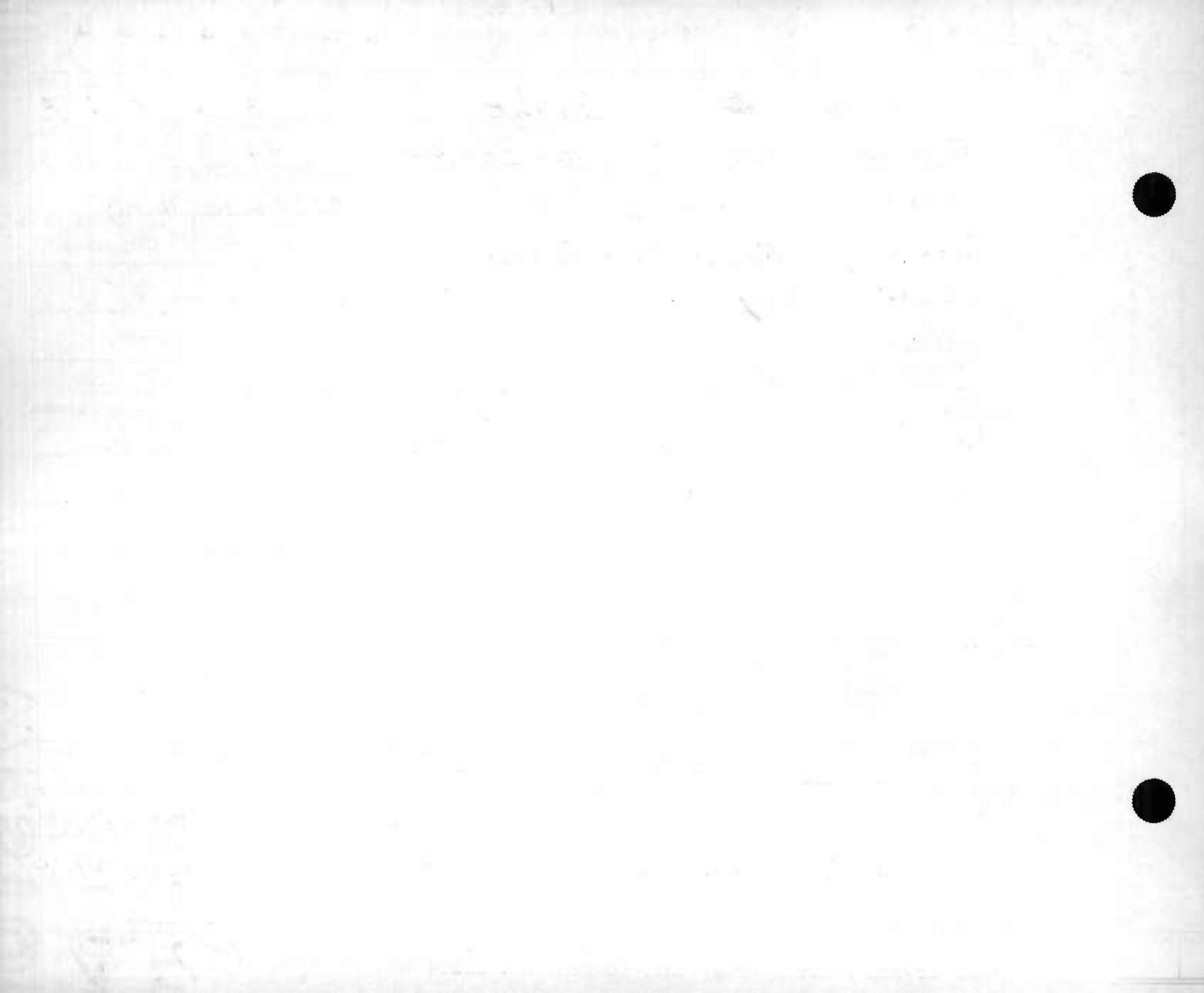
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Anna M. Sagle</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-16-80</b>			2b. HOUR <b>3:55 AM</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10-20-1895</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD				
10 CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mahor Care Towson</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>William Cunzeman</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria Hammond</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>214-24-3234 A</b>		17. INFORMANT ADDRESS <b>Dorothy S. Mc Mann 9513 Dawnvale Road</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR COLLAPSE</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF LUNG</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hr</b> <b>8 MO</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>19 65</b> to <b>MARCH 16</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>MARCH 16</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE <b>Samuel O'Man Sky</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <b>March 16, 1980</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SAMUEL O'MAN SKY</b>						22e. ADDRESS <b>8405A LOCHRAVEN BLVD 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>3-17-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b> ADDRESS <b>1050 York Rd.</b>						25a. DATE REC'D BY REGISTRAR <b>18 MAR 1980</b>		25b. REGISTERED SIGNATURE <b>[Signature]</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>MARIE P. SANDRUCK</b>					2a. DATE OF DEATH MONTH <b>3</b> DAY <b>13</b> YEAR <b>80</b>		2b. HOUR <b>12:42 AM</b>		
3. SEX <b>F</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>MAY</b> DAY <b>14</b> YEAR <b>1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.J.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CO.</b> MD.					
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTO. CO. GEN. HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>			
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>PIRESVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7416 MONITA RD.</b>			
14. FATHER'S NAME FIRST <b>EMANUEL</b> MIDDLE <b>PUENTES</b> LAST <b>PUENTES</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MARY</b> MIDDLE <b>KELLY</b> LAST <b>KELLY</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <b>MARGUERITE S. CALEY SAME 21208</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure (sanguine)</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ischemic Cardiovascular Disease</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>46 of Cerebrovascular Accident</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <b>3/13/80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>3/13/80</b> to <b>3/17/80</b> , that (I) (we) lost saw the deceased alive on <b>3/13/80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <b>3/13/80</b>	
22b. SIGNATURE <b>Bernard D. Gonzalez</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BERNARD D. GONZALES</b>		22e. ADDRESS <b>BALTIMORE CO. GEN. HOSP.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3-14-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATH. CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. CITY MD.</b>					
24. FUNERAL DIRECTOR NAME <b>NEWELL F.H.</b>		ADDRESS <b>1100 REISTERSTOWN RD.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Mary McCreedy</b>					





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Herman A. SAPP SR		2a. DATE OF DEATH MONTH DAY YEAR March 30, 1980		2b. HOUR 10:40 AM	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 11/2/14		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AIRCRAFT	
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN MIDDLE RIVER	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN SAPP		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHESIE ADAMS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 03 3189		17. INFORMANT ADDRESS GERTRUDE SAPP ABOVE	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1: DEATH WAS CAUSED BY

Cardio-Pulmonary Arrest

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

4275  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Probable Cardio Vascular Arrest with Hypoxic  
Damage

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that X (this hospital) attended the deceased from February 19, 1980, to March 30, 1980, that (X) (we) last saw the deceased alive on March 30, 1980, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death.							
27a. SIGNATURE W. Suarez		27b. PHYSICIAN'S NAME (TYPE OR PRINT) W. Suarez, MD				27c. DATE SIGNED 3/30/80	
		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
		27d. ADDRESS 9000 Franklin Sq. Dr., Balto., MD 21237					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/2/80		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD	
24. FUNERAL DIRECTOR NAME CONNELLY F.H.		ADDRESS 300 MACE AVE		25a. DATE REC'D. BY REGISTRAR APR 3 1980		25b. REGISTRAR'S SIGNATURE Ricky McQuinn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



APR 1980  
BUREAU OF LAND MANAGEMENT  
U.S. DEPARTMENT OF AGRICULTURE

Handwritten notes and a table on lined paper. The notes include "1/2/80" and "21". The table has several rows with handwritten entries, including "24", "25", "26", "27", "28", "29", "30", "31", "32", "33", "34", "35", "36", "37", "38", "39", "40", "41", "42", "43", "44", "45", "46", "47", "48", "49", "50", "51", "52", "53", "54", "55", "56", "57", "58", "59", "60", "61", "62", "63", "64", "65", "66", "67", "68", "69", "70", "71", "72", "73", "74", "75", "76", "77", "78", "79", "80", "81", "82", "83", "84", "85", "86", "87", "88", "89", "90", "91", "92", "93", "94", "95", "96", "97", "98", "99", "100".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0006203	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) ISABELLA W. SAWYER						2a. DATE OF DEATH MONTH DAY YEAR March 7, 1980			2b. HOUR 11:00 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 17, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 77		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Ruxton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS formerly 204 E. Joppa Road			
14. FATHER'S NAME FIRST MIDDLE LAST unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Watterston							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 143-24-2814		17. INFORMANT ADDRESS Mr. George W. Sawyer, Jr. 22 Aigburth Road							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bronchitis</u> 4871 DUE TO, OR AS A CONSEQUENCE OF (b) <u>INFLUENZA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE - SENILITY</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>2-8-1980</u> to <u>MAR 7, 1980</u> , that (1) (we) lost saw the deceased alive on <u>JAN 21, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (do) (did not) view the body after death.											
22b. SIGNATURE <u>S. J. Venable, Jr. M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3-8-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. J. Venable, Jr. M.D.				22e. ADDRESS 7215 York Road							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-11-1980		23c. NAME OF CEMETERY OR CREMATORY Hillside		23d. LOCATION CITY OR TOWN COUNTY STATE Lyndhurst Bergen New Jersey					
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Maryland				ADDRESS 1050 York Road		25a. DATE REC'D. BY REGISTRAR MAR 11 1980		25b. REGISTRAR'S SIGNATURE <u>Richard M. Brady</u>			



*[Faint, mostly illegible handwritten text and markings across the page, including numbers and names.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0 0 6 2 0 4	
1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) <b>HOWARD L. SCHMIDT</b>				2a DATE OF DEATH MONTH DAY YEAR <b>MAR. 22/80</b>		2b HOUR <b>1:45 P.M.</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>1 5 1905</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co.</b> MD.					
10 CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Checker</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Amer. Ice Co.</b>			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md.</b>				13b COUNTY <b>Carroll</b>		13c CITY OR TOWN <b>Westminster</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>198 E. Green Street</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Gottlieb Schmidt</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Bennett</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b SOCIAL SECURITY NO. <b>215-10-8160</b>		17 INFORMANT ADDRESS <b>Mrs. Doris Barnes, Westminster, Md.</b>					
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute pulmonary Edema</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Chronic Obstructed Pulmonary Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>Cardiac Arrhythmia</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, Cardiovascular Disease</b>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <b>3/22</b> 19 <b>80</b> , to <b>3/22</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>3/22</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>Bernardo D. Gonzalez Jr</b>				DEGREE <b>MD</b>				22c DATE SIGNED <b>3/22/80</b>			
22e PHYSICIAN'S NAME (TYPE OR PRINT) <b>Bernardo D. Gonzalez</b>				22e ADDRESS <b>Baltimore County Gen. Hosp</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>3-25-80</b>		23c NAME OF CEMETERY OR CREMATORY <b>Hampstead Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Hampstead Carroll Md.</b>					
24 FUNERAL DIRECTOR NAME ADDRESS <b>Eline Funeral Home, Hampstead, Md. 21074</b>				25a DATE REC'D. BY REGISTRAR <b>MAR 26 1980</b>		25b REGISTRAR'S SIGNATURE <b>Hickey McCreedy</b>					



Acute Pulmonary Tuberculosis  
Chronic Bronchitis Pulmonary Disease  
Cardiac Insufficiency  
Arteriosclerotic Cardiovascular Disease

08 SEP 68 02 00/00 00/00

09/00/00 or 00/00/00  
00/00/00 00/00/00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-2222.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 0 0 6 2 0 5	
CERTIFICATE OF DEATH		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Oswald		LAST Schmidt		2a. DATE OF DEATH MONTH DAY YEAR MARCH 19, 1980	
3 SEX MALE		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7-28-48	
6 AGE (IN YEARS LAST BIRTHDAY) 81		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, 21234 MD.		10 CITY OR TOWN OF DEATH Baltimore City	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PEKING ARWAY NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret Salesman		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14 FATHER'S NAME FIRST MIDDLE LAST J. Hern Schmidt		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Kahler		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	
16b. SOCIAL SECURITY NO 214 24 5059		17 INFORMANT Mary W. Wright		18 ADDRESS 410 Latimer Rd. Joppatown	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis - 4370 DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) General Arteriosclerosis -				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hxemia A -					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/17/80 to 3/19/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Anthony F. Carr 77A				22c. DATE SIGNED 3-20-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 1801 Wentworth Rd Baltimore 21234	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/22/1989		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
23d. LOCATION CITY OR TOWN Woodlawn		23e. COUNTY Md		23f. STATE	
24 FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home				24b. ADDRESS 6500 YORK RD	
25a. DIED BY REGISTRY				25b. REGISTRAR'S SIGNATURE MAR 26 1980	



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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 0 6 2 0 6			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR	
Raymond S. SCHNEIDER				3 30 80		2b. HOUR	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
Male		White		Feb. 8, 1927		53	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				Baltimore County MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Franklin Square Hospital		Project Analyst		G. & E. Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
Maryland		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8919 Mavis Ave. 21236	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Andrew G. Schneider		Kathleen Stevenson		Yes		WW II 220-18-8739	
17 INFORMANT		17 ADDRESS		17 Mary Helen Schneider, wife, same address			
18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Asystole</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7-10 hrs.</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>John J. Messina</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/31/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John J. Messina, M.D.		22e. ADDRESS 7401 Osler Dr., Towson, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/2/80		23c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24 FUNERAL DIRECTOR S. Calumnek Funeral Home, Inc.		9705 Belair Rd. Balto., Md. 21236		25a. DATE REC'D. BY REGISTRAR APR 1 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

7074

Carbon 5000  
4000

10/2/20

*[Signature]*  
John J. Williams, M.D.

John J. Williams, M.D., 711 N. 1st St., St. Louis, Mo.

*[Signature]*

Dr. Williams' Pink Pills  
for Pale People

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1STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 0 6 2 0 7

1. DECEASED NAME (TYPE OR PRINT) Rose Cecila SCHNEIDER			2r. DATE OF DEATH MONTH DAY YEAR March 23, 1980			2b. HOUR 7:05 a M						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 22, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7r. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.						
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales		12b. KIND OF BUSINESS OR INDUSTRY Hess shoes				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.						13b. COUNTY Balto.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John Adams						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Sheridan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 197-01-8186		17. INFORMANT ADDRESS Mrs. Sharon Rusinovich same						
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 4589 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Septicemia (c) Hypotension DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21r. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21i. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that X (this hospital) attended the deceased from March 22, 1980, to March 23, 1980, that X (we) last saw the deceased alive on March 23, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (do not) view the body after death.												
22b. SIGNATURE Raul Masvidal MD						DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/23/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raul Masvidal MD						22r. ADDRESS 9000 Franklin Square Drive 21237						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 25, 1980		23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial			23d. LOCATION CITY OR TOWN COUNTY STATE Eldersburg Carroll Md.				
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland						25r. DATE REC'D. BY REGISTRAR MAR 24 1980		25b. REGISTRAR'S SIGNATURE [Signature]				





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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHRISTIAN SCHORK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 16, 1980</b>		2b. HOUR <b>7:20p</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov 5 1901</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SAINT JOSEPH HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Police Sgt.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>			
13a. STATE <b>MD</b>			13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Balto</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael Schork</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Ringwald</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 2 212 46 2622</b>		17. INFORMANT <b>XXXXXX family records</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular thrombosis and stroke</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary insufficiency</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Myocardial ischemia</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 1, 1980</b> to <b>March 16, 1980</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>March 16, 1980</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.						
22b. SIGNATURE <b>AH. Ghiladi M.D.</b>				22c. DATE SIGNED <b>March 17, 1980</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>AH. GHILADI, M.D.</b>				22e. ADDRESS <b>7600 OSLER Dr. Towson 21204</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/19/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		
24. FUNERAL DIRECTOR NAME <b>Evans Funeral Chapel</b>		ADDRESS <b>8800 Harford Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 24 1980</b>		
				25b. REGISTRAR'S SIGNATURE <b>Pietro/No Brady</b>		

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REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
KARL		MARCH 26, 1980		5:00P M	
3. SEX		4 RACE		5. DATE OF BIRTH	
MALE		WHITE		5 MONTH 12 DAY YEAR 10	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
PENNSYLVANIA		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
FORT HOWARD		V. A. MEDICAL CENTER		Retired	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND		PRINCE GEORGE FORRESTVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS	
FIRST MIDDLE LAST Joseph Schraf		FIRST MIDDLE LAST Rose Porta		2809 KIRTLAND AVENUE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES (IF YES, GIVE WAR OR DATES) WWII		171 07 3084		CLINICAL RECORDS, VAMC, FORT HOWARD, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> 486- DUE TO, OR AS A CONSEQUENCE OF (b) <b>RESPIRATORY INSUFFICIENCY SECONDARY TO:</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>BILATERAL PNEUMONIA</b> 3 DAYS 3 DAYS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 9/5, 19 79, to 3/26, 19 80, that (we) lost saw the deceased alive on 3/26/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (and) (and) view the body after death.					
22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> JOSEPH W. ZEBLEY, M. D.				22c. DATE SIGNED 3/26/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS VAMC, FORT HOWARD, MARYLAND 21052	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/31/80		23c. NAME OF CEMETERY OR CREMATORY Maryland Vet. Cemetery Cheltenham Md.	
24. FUNERAL DIRECTOR NAME ADDRESS G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR APR 1 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the coronator's death record in the office of the coronator. The original of this certificate should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

IN REPLY TO

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06210	
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST						2a. DATE KNOWN OF DEATH				2b. HOUR					
ROSE						MILLER						SCHRETER				<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 3 3 1980				M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR		8. IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD				2d. HOUR					
female		white		SEPT. 19, 1913		66		MONTHS DAYS HOURS MIN				3 3 1980				7:30					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH						MD			
NEBRASKA				USA								Baltimore County									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Randallstown				Baltimore Co. Gen'l Hospital								HOUSEWIFE				AT HOME					
13a. STATE										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLAND												BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		APT. 204 6210 PARK HTS. AVE. #21215					
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST						FIRST MIDDLE LAST															
ISADORE						SHAHER						BERTHA GAITMAN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT									
NO						214-56-9746						MR. SIDNEY H. SCHRETER 6210 PARK HTS. AVE., APT. 204 BALTO., MD 21215									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) <b>Cranio-cervical injuries</b>																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																					
(b) DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
																YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
						6:55 P.M. 3 3 1980						pedestrian struck by auto									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION									
						highway						Patterson Ave. & Wildwood Ave. Baltimore, Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED									
DR. A YANELL						MED. EXAMINER'S OFFICE						BALTO., MD									
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION									
BURIAL						MAR. 6, 1980		BETH JACOB				FINKSBURG CARROLL MD									
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE									
SOL LEVINSON & BROS., INC.						MAR 11 1980						History McCreedy									
6010 REISTERSTOWN RD. BALTO., MD 21215																					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 6 2 1 1			
1. DECEASED NAME (TYPE OR PRINT) <b>JAMES E. Scott SR.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3 18 80</b>			
3 SEX <b>MALE</b>		4 RACE <b>NEGRO</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 7, 1925</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Balto. Co. Gen. Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Warehouse</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MD.</b> 13c. CITY OR TOWN <b>Balto</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS <b>460 Shirley Manor Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Scott</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Irma Keyga</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-22-4808</b>		17. INFORMANT <b>Annetta Scott</b>		ADDRESS <b>2906 Violet Ave. Balto. Md. 21215</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Lung Cancer</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>-</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>-</b>							
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>-</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>-</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>- - - - -</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>3-11-1980</b> , to <b>3-18-1980</b> , that (I) (we) last saw the deceased alive on <b>3-18-1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>S. Patel</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3-18-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. SUDHIR D. PATEL</b>				22e. ADDRESS <b>Bal. County Gen. Hosp. Old Court. Rd. Bal. MD. 21133</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>MAR. 21, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Piney Grove Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Boring, Balto. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>H. J. Schmitt</b>		ADDRESS <b>Owings Mills, Md.</b>		25a. DATE FILED <b>MAR 21 1980</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

0 0 6 2 1 2

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LOUISE C. SCOTT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 17, 1980</b>			2b. HOUR M <b>AM</b>			
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 14 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>56</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>IF UNDER 24 HRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>242 Bethel Court</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Boisy Carter</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Betty Gore</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>248-98-4089</b>		17. INFORMANT ADDRESS <b>Elizabeth Bass 5216 Ivanhoe Ave.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multisystem failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>	
4239 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>anoxic damage</b>		1 week	
(c) <b>cardiopulmonary arrest</b>		1 week	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION <b>13 March 1980</b> <b>10 March 1980</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Tracheostomy - Pulmonary toilet</b> <b>Persistent tamponade, atrial bleeding</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>BALTIMORE CITY HOSPITALS, BALTIMORE</b>		CITY OR TOWN COUNTY STATE	
22a. I certify that (1) <del>the hospital</del> attended the deceased from <b>10 March</b> , 19 <b>80</b> , to <b>17 March</b> , 19 <b>80</b> , that (1) <del>was</del> last saw the deceased alive on <b>17 March</b> , 19 <b>80</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>did</del> view the body after death.							
22b. SIGNATURE <b>BRADFORD B. WALTERS</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>17 March 1980</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BRADFORD B. WALTERS</b>		22e. ADDRESS <b>BALTIMORE CITY HOSPITALS, BALTIMORE</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/22/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. MD</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1980</b>	
				25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			



12 APR 1980  
10 APR 1980  
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12 APR 1980  
10 APR 1980  
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12 APR 1980  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT D. SCOTT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-28-80</b>			2b. HOUR <b>2:30 PM</b>				
3 SEX <b>Male</b>		4 RACE <b>CAU</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>NOV 7 1906</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		7. # UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Scotland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore MD</b>				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore Co. Gen. Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>wood</b>		
13a. STATE <b>MD.</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Woodlawn</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>3 3 Scott</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary ? Homes</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				
16b. SOCIAL SECURITY NO. <b>218-09-5375</b>			17. INFORMANT ADDRESS <b>Geraldine Scott 6716 Richardson Av.</b>							

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY Arrest</b> <b>5570</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>VENTRICULAR ARRHYTHMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
**SEPSIS, PNEUMONIA, CONGESTIVE HEART FAILURE, RENAL FAILURE**

19a. DATE OF OPERATION <b>3-18-80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RESECTION OF GANGRENOUS SMALL BOWEL ANASTOMOSIS</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22. I certify that (I) (this hospital) attended the deceased from **3-15 19 80** to **3-28 19 80**, that (I) (we) lost saw the deceased alive on **3-28 19 80** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <b>Orlando B. Conanan</b>		DEGREE		22c. DATE SIGNED <b>3-28-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ORLANDO B. CONANAN, MD.</b>		22e. ADDRESS <b>BRETT RANDALLS TOWNS MD. 21137</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>31 March</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Balto MD</b>	
24. FUNERAL DIRECTOR NAME <b>J.T. Stansbury, Jr.</b> ADDRESS <b>6411 Windson Mill Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 2 1980</b>		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO. 006214			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAY SHA LOWITZ				2a. DATE OF DEATH MONTH DAY YEAR 3-6-80		2b. HOUR 11:35 AM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4-25-88		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. PLACE OF BIRTH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DIETICIAN		12b. KIND OF BUSINESS OR INDUSTRY UNION MEM. HOSP.	
13a. STATE MARYLAND		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN TABAKMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-22-1775A		17. INFORMANT MR. MARION SHA LOWITZ 2900 N. LEXINGTON ST., ARLINGTON, VA 22207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> 4140 DUE TO, OR AS A CONSEQUENCE OF <u>with pulmonary edema</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF <u>pneumonia</u> (c) _____ Approximate interval between onset and death: <u>days</u> <u>weeks</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Seizure disorder</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-23-</u> 19 <u>80</u> , to <u>3-6-</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>3-6-</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Soonchal Hong</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3-6-80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SOON CHUL HONG</u>		22e. ADDRESS <u>Baltimore County General Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>MAR. 9, 1980</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HEBREW YOUNG MEN</u>		23d. LOCATION <u>BALTIMORE</u> COUNTY <u>MARYLAND</u>	
24. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., INC.</u> NAME ADDRESS <u>6010 REISTERSTOWN RD., BALTO., MD 21215</u>				25a. DATE REC'D. BY REGISTRAR <u>MAR 11 1980</u>		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>	



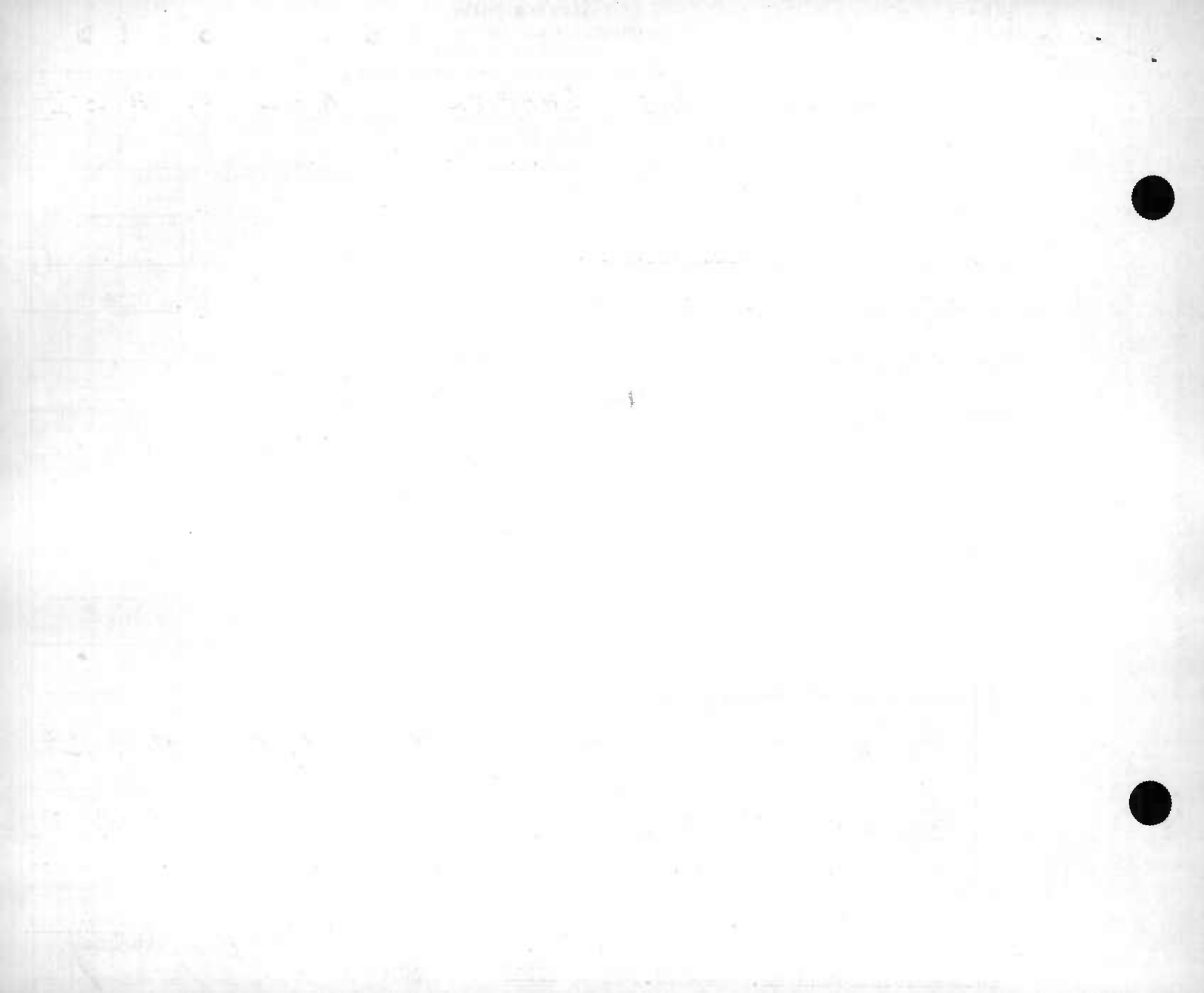


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
REG. NO. 0006215									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HANNAH RAE SHAPIRA					2a. DATE OF DEATH MONTH DAY YEAR MAR 10, 1980		2b. HOUR 5:40 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT. 13, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DULANEY-TOWSON NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETAILER		12b. KIND OF BUSINESS OR INDUSTRY WOMEN'S CLOTHES	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3501 PHILLIPS DR. #21208	
14. FATHER'S NAME FIRST MIDDLE LAST JACOB SHAPIRA					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA BAWORSKY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 209-01-1001A		17. INFORMANT BURTON L. HIRSCH FUNDAL HOME 2704 MURRAY AVE., PITTSBURGH, PA 15217					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>AC &amp; CH. Cereb. HT. Failure</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b). <u>AS EVD.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE P.O. 3/10 P.O. WFE					
22a. I certify that (this hospital) attended the deceased from <u>3/9</u> 19 <u>80</u> to <u>3/10</u> 19 <u>80</u> , that (we) lost saw the deceased alive on <u>3/9</u> 19 <u>80</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Raymond N. Caplan, M.D.</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>3/10/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND N. CAPLAN, M.D.				22e. ADDRESS 2435 W. BELVEDERE AVE. BALTO., MD 21215					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL/BURIAL		23b. DATE MAR. 10, 1980		23c. NAME OF CEMETERY OR CREMATORY BNAT ISRAEL		23d. LOCATION CITY OR TOWN COUNTY STATE PITTSBURGH PENNSYLVANIA			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.				25a. DATE REC'D. BY REGISTRAR MAR 11 1980		25b. REGISTRAR'S SIGNATURE <u>Raymond N. Caplan</u>			
6010 REISTERSTOWN RD. BALTO., MD 21215									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

0 0 6 2 1 6

1. DECEASED NAME (TYPE OR PRINT) David Holly Shaughnessy			2a. DATE OF DEATH MONTH DAY YEAR 3-24-80			2b. HOUR 12 05 AM					
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 1 1894		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS P 23		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 3115 Shannon Drive				
14. FATHER'S NAME FIRST MIDDLE LAST Edward Shaughnessy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Curtin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 1918		17 INFORMANT Stella Maris Hospice		ADDRESS Dulaney Valley Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>General Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>1-26</u> , 19 <u>72</u> , to <u>3-24</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3-21</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3-24-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. David Nagel					22e. ADDRESS 1205 York Rd. Lutherville, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/24/80		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.					ADDRESS Baltimore, Maryland		DATE REC'D. BY REGISTRAR MAR 26 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

50 06217

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Baby Boy SHERIN "A"		2a. DATE OF DEATH MONTH DAY YEAR 3 8 80		2b. HOUR dof AM
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 8 80		6. AGE (IN YEARS LAST BIRTHDAY) Premature newborn YRS. MONTHS DAYS ? ?
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2108 Meadowview Drive 21207		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. CITY OR TOWN Woodlawn	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS 2108 Meadowview Dr. Same as above
14. FATHER'S NAME FIRST MIDDLE LAST Robert W. Sherin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Inez M. Stern		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. —		17. INFORMANT Parents - same as above

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardio-respiratory failure { intracranial hemorrhage 7704 DUE TO, OR AS A CONSEQUENCE OF: (b) Prematurity - very immature DUE TO, OR AS A CONSEQUENCE OF (c) pulmonary & CNS system.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) General Prematurity		

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 3 8 1980	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Premature delivery - Abortion, Spont.	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.			
22b. SIGNATURE Samuel R. Williams, MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 3/8/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel R. Williams, MD		22e. ADDRESS St. Agnes Hospital	

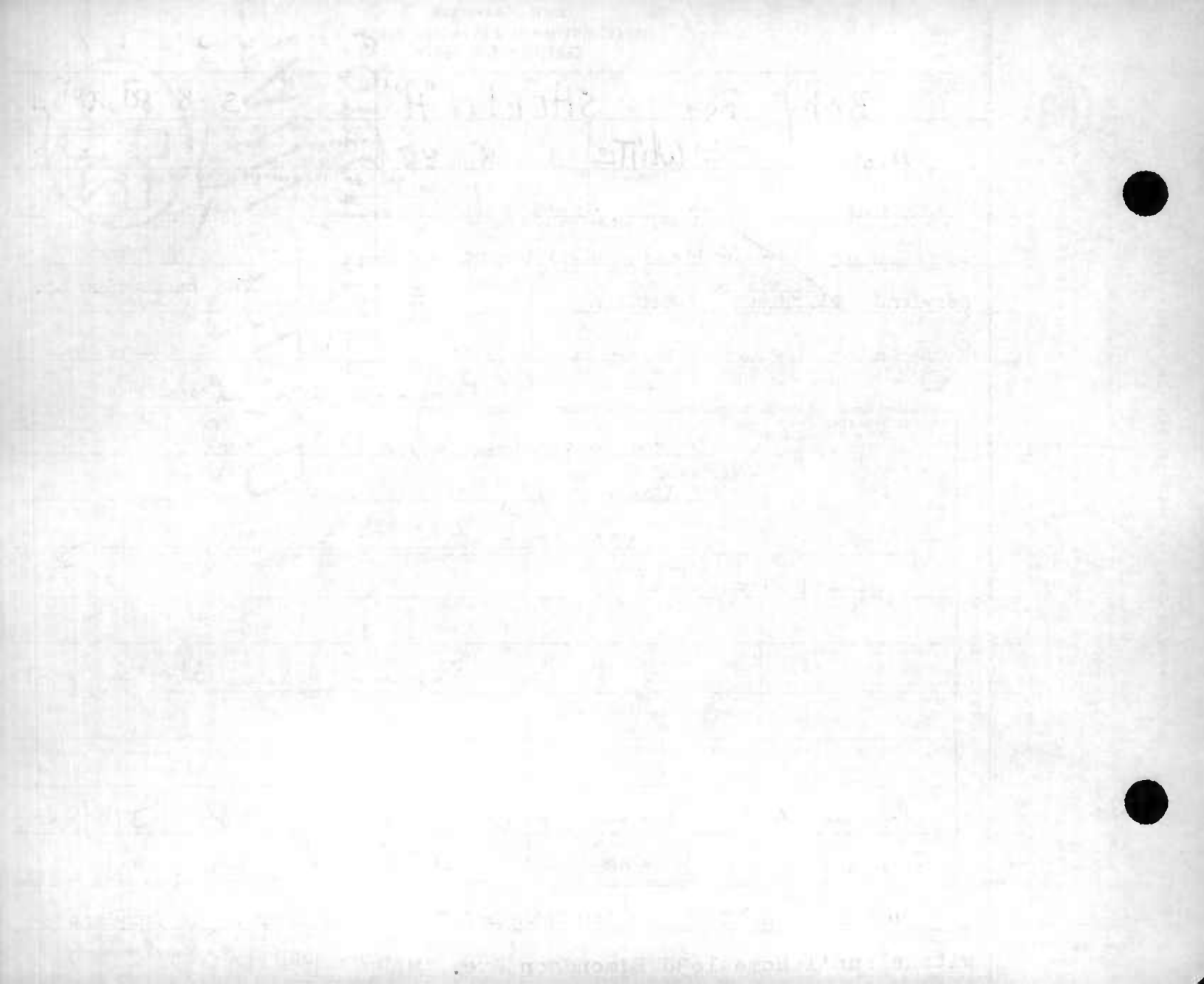
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/22/80	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Witzke Fun'l Home 1630 Edmondson Ave.		25a. DATE REC'D. BY REGISTRAR MAR 26 1980	25b. REGISTRAR'S SIGNATURE Jeffrey McCreedy

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

4024 BP



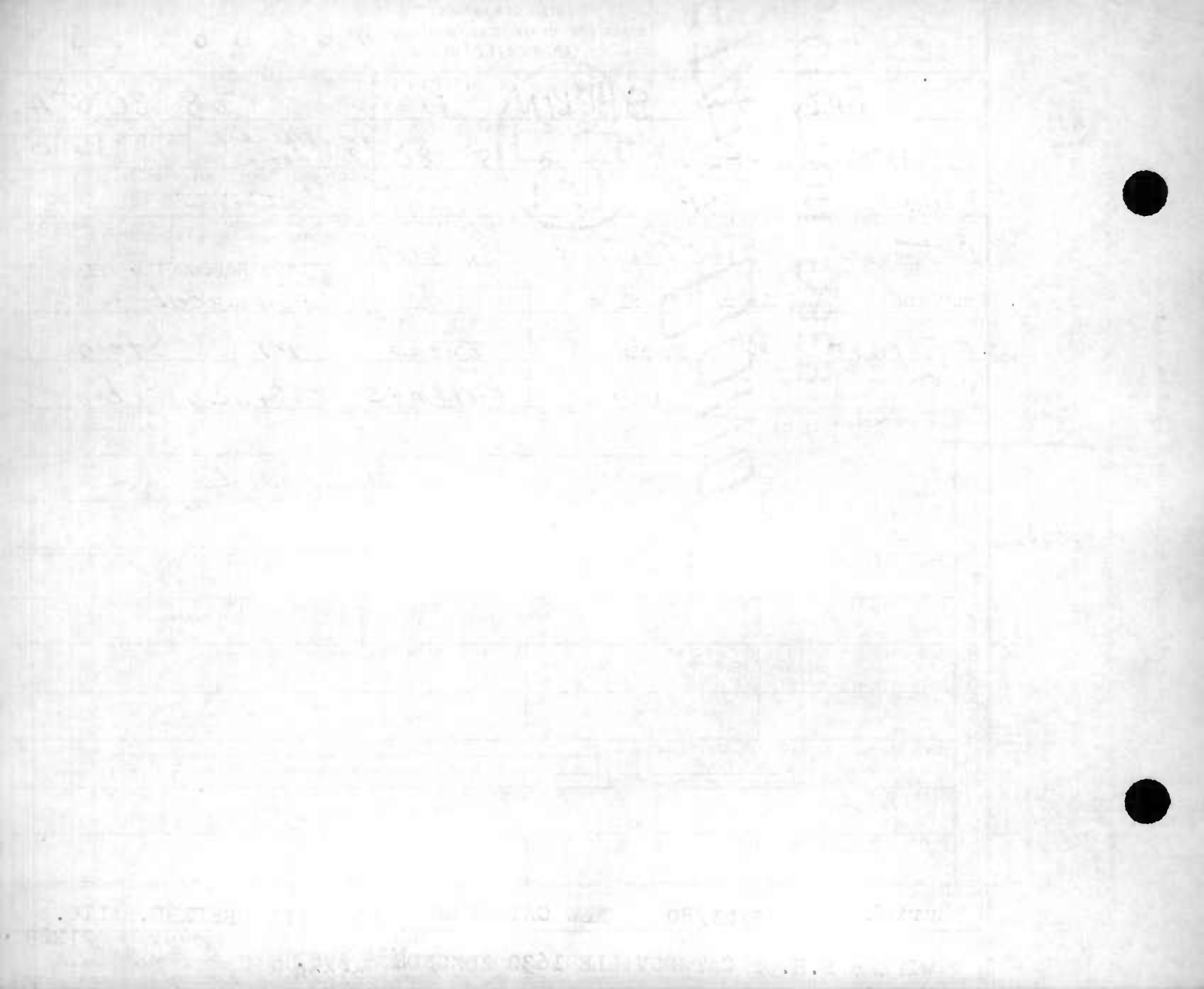
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0006218					
1. FOR STATE REGISTRAR										2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Baby Boy SHERIN "B"										3-8 80				10:00 A.M.	
3. SEX male			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 8 80			6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN. ? ?		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? 16A			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.						
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2108 Meadowview Drive							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -			12b. KIND OF BUSINESS OR INDUSTRY -		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Same as above						
14. FATHER'S NAME FIRST MIDDLE LAST Robert W. Sherin					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Inez M. Stein										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) 0			16b. SOCIAL SECURITY NO. None			17. INFORMANT Parents			ADDRESS Same as above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardioresp Arrest. 7704										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity + Immature Lungs															
DUE TO, OR AS A CONSEQUENCE OF (c) 8															
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE [Signature] DEGREE										ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/8/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/21/80		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL			23d. LOCATION CITY OR TOWN COUNTY STATE 4300 OLD FREDKRD. BALTO.							
24. FUNERAL DIRECTOR NAME WITZKE F.H. OF CATONSVILLE 1630 EDMONDS										25a. DATE REC'D. BY REGISTRAR MAR 3 1980		25b. REGISTRAR'S SIGNATURE [Signature]			







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO. 006219			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <b>JULIANITA E. Shield</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3-25-80</b>		2b. HOUR <b>8:46 A.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>02 05 20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk-Pikesville</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hardware</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>-</b> 13c. CITY OR TOWN <b>Baltimore</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4210 Fords Lane, 21215</b>	
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>J.</b> LAST <b>Bruckner</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Edna</b> MIDDLE <b>Elizabeth</b> LAST <b>Thomas</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>214-16-9012</b>		17. INFORMANT ADDRESS <b>Homer E. Shield, 4210 Fords Lane, 21215</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 MIN.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CARDIOGENIC SHOCK</b>						30 MIN.	
(c) <b>MASSIVE MYOCARDIAL INFARCTION</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>3/25/80</b> to <b>3/25/80</b> , that (1) (we) lost saw the deceased alive on <b>3/25/80</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Bernard Rubin</b> DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3/25/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BERNARD RUBIN, MD</b>				22e. ADDRESS <b>3502 CROYDON ROAD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/28/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn, Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors P.A.</b> ADDRESS <b>8728 Liberty Road, Randallstown, Md. 21133</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Pistroy Melroedy</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Henry William SHOOK			2a. DATE OF DEATH MONTH DAY YEAR March 4, 1980			2b. HOUR 11:21 <sup>P</sup> AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 24, 1895		6. AGE (IN YEARS (LAST BIRTHDAY)) 84 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Standard Oil	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5600 Greenhill Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Kasper Shook					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Zuker				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-01-4057A		17. INFORMANT ADDRESS Mary E. Shook, 5600 Greenhill Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ventricular Dysrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Septicemia</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from February 24, 1980, to March 4, 1980, that (we) lost saw the deceased alive on March 4, 1980, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.									
22b. SIGNATURE Ange Vento					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/4/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ange Vento					22e. ADDRESS 9000 Franklin Square Drive 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 8, 1980		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto., Md.		
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214					25a. DATE REC'D. BY REGISTRAR MAR 5 1980		25b. REGISTRAR'S SIGNATURE [Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8006221	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) SEYMOUR SILVERBROOK				2a. DATE OF DEATH MONTH DAY YEAR 3 12 80		2b. HOUR 9:42 PM			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR AUG. 6, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH RANDALLSTOWN BALTO. CO. MD.					
10 CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY POST OFFICE			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. CITY OR TOWN PHILADELPHIA		13b. STREET ADDRESS 3708 RONNARD DR. #19154					
14 FATHER'S NAME FIRST MIDDLE LAST ALBERT EDWARD SILVERBROOK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE UNKNOWN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WWII-ARMY 159-18-5369		17 INFORMANT MRS. EDNA SILVERBROOK 3708 RONNARD DR., PHILA., PA 19154							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute MI 410- DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS 70 years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3-12-80 to 3-12-80, that (we) (not) saw the deceased alive on 3-12-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death.											
22b. SIGNATURE M.B. PEARLMAN				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-12-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.B. PEARLMAN				22e. ADDRESS 3708 RONNARD DR. BALTO. MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		23b. DATE MAR 13 1980		23c. NAME OF CEMETERY OR CREMATORY SHALOM MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE PHILADELPHIA PENNA.					
24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD. 21215				25. DATE RECEIVED BY REGISTRAR MAR 18 1980		25b. REGISTRAR'S SIGNATURE [Signature]					







FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

006222

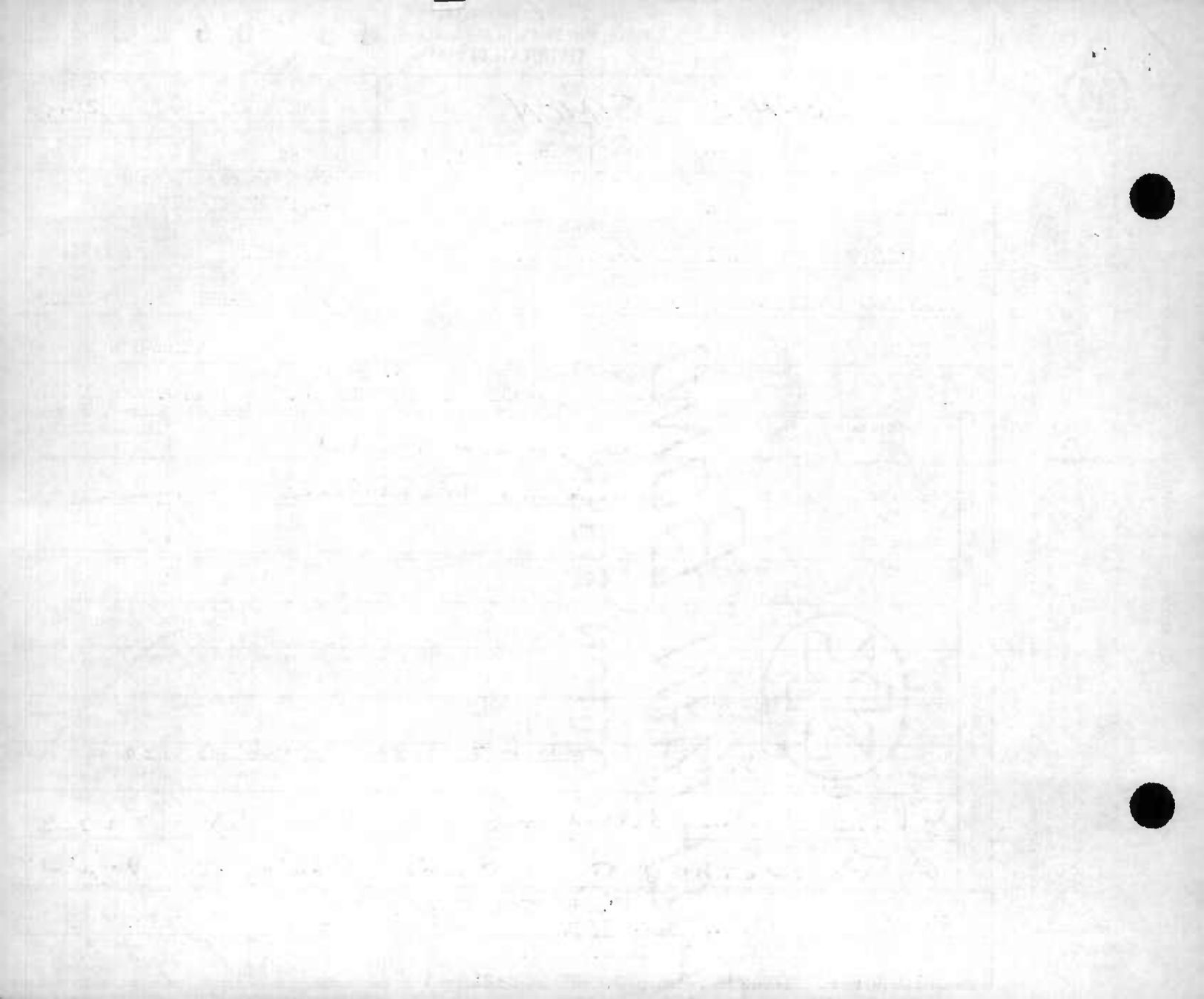
1. DECEASED NAME (TYPE OR PRINT) <b>SOPHIE SIMON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 23, 1980</b>			2b. HOUR <b>2:45 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APR. 1, 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>XXX</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>PASHA SIMON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>RUSHIE UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-16-3660D</b>		17. INFORMANT <b>MRS. BETTY CANNON</b> <b>3206 SOUTHGREEN RD. BALTO., MD 21207</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident.</b> <b>436 -</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. certify that (I) (this hospital) attended the deceased from <b>march 7, 19 80</b> , to <b>march 23, 19 80</b> , that (I) (we) last saw the deceased alive on <b>march 23, 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Sharon P. ...</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>7-27-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. PORMETABED</b>				22e. ADDRESS <b>Balto. County Gen. Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>MAR. 24, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>(LAZER RISSA SKLAR FAMILY CIRCLE)</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1980</b>			
25b. REGISTRAR'S SIGNATURE <b>Barry McCreedy</b>				25c. ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



RELEASED BY MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ANNIE N. SIMPSON				2a. DATE OF DEATH MONTH DAY YEAR MARCH 6, 1980			
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR June 18, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian, ret.		12b. KIND OF BUSINESS OR INDUSTRY Amtrak	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Edmond Nance				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mariah Phillip			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 577-24-0222		17. INFORMANT ADDRESS Indianapolis, Ind. Alberta Carey, daughter, 5534 Grandview Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 586- DUE TO, OR AS A CONSEQUENCE OF (b) <u>C.H.F.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Renal Failure ASCUD</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 Weeks Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION January 31, 1980		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Occlusion left common iliac artery		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 14, 1980, to March 6, 1980, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on March 6, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE <i>Dr. Boas</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED March 7, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence Boas, M.D.				22e. ADDRESS 50 Scott Adam Rd., Cockeysville, MD 21030			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 13, 80		23c. NAME OF CEMETERY OR CREMATORY New Bethel AME Ch.Cty.		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, South Carolina	
24. FUNERAL DIRECTOR NAME McGuire Funeral Service, Inc., 7400 Ga. Ave. NW				25a. DATE REC'D. BY REGISTRAR MAR 18 1980		25b. REGISTRAR'S SIGNATURE <i>Robert McCreary</i>	

BP



WINDMILL  
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06224							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES John SKARDA										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 4 19 80										2b. HOUR M 6:30 P M							
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12-24-1918		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 4 19 80				2d. HOUR M 6:30 P M											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. City MD.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD															
10. CITY OR TOWN OF DEATH Essex				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Guard				12b. KIND OF BUSINESS OR INDUSTRY Franklin Square Hosp.															
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE Md.										13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 118 Leslie Avenue-21236	
14. FATHER'S NAME FIRST MIDDLE LAST George										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Natherine																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes Army WWII										16b. SOCIAL SECURITY NO. 219-05-7247										17. INFORMANT Mrs. Helen Holthaus		ADDRESS 118 Leslie Ave.-21236					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																											
ACTUAL SIGNATURE Ann M. Dixon, M.D.										TITLE (SPECIFY) Assistant MEDICAL EXAMINER										DATE SIGNED 3-5-80							
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.										ADDRESS 111 Penn St.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3-7-80				23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.															
24. FUNERAL DIRECTOR NAME John C. Miller Inc.										ADDRESS 6415 Belair Rd.-21206										25a. DATE REC'D. BY REGISTRAR MAR 10 1980		25b. REGISTRAR'S SIGNATURE John C. Miller					

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Yours truly,  
J. Edgar Hoover

5. *Staph.*

*(Signature)*

1992

7-10-68, 11-10-68, 12-10-68, 1-10-69

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



1- FOR  
STATE  
REGISTRAR

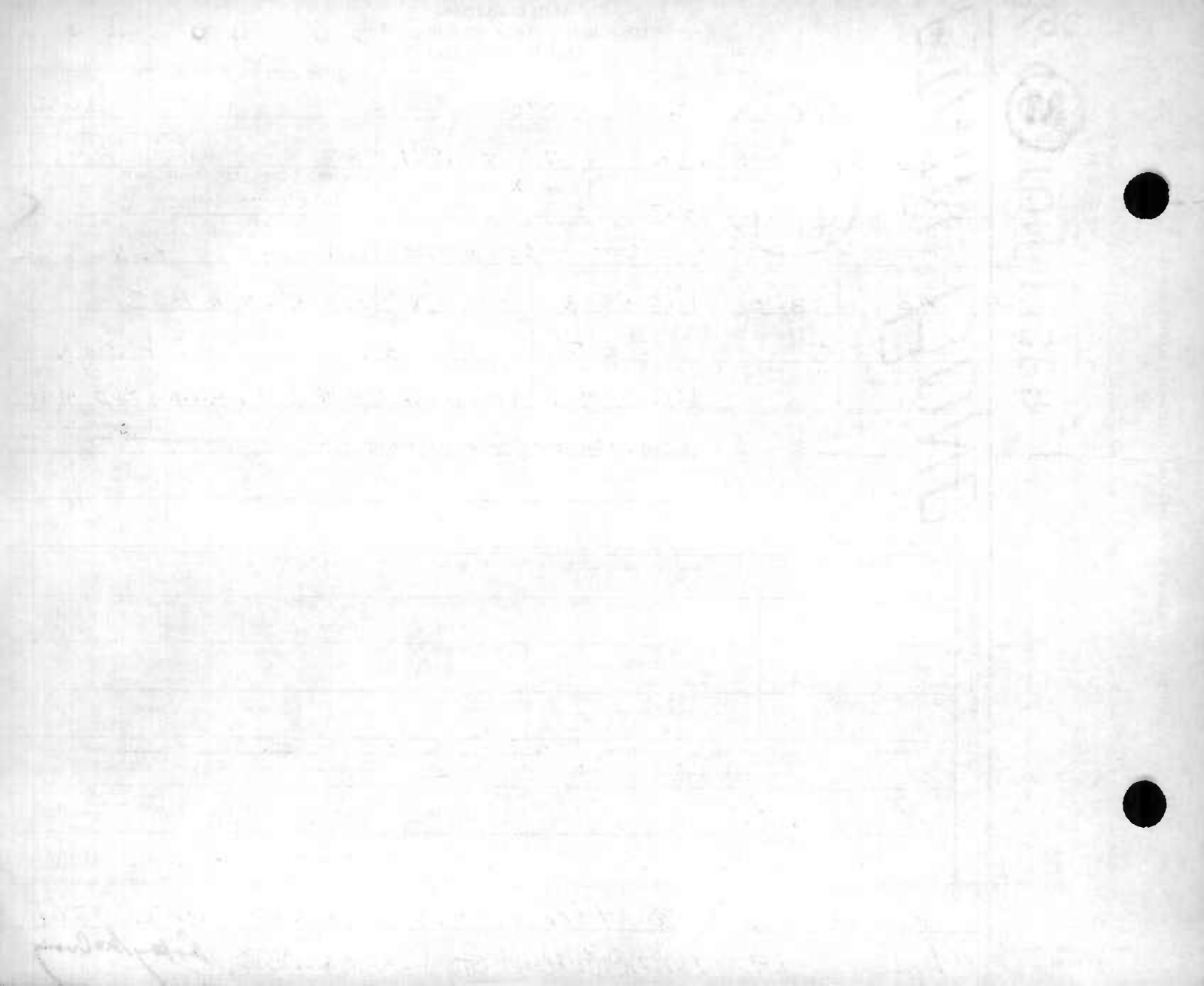
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Charles A. Smith</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 3 80</b>			2b. HOUR <b>12:34AM</b>				
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 4 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Baltimore Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>		
13a. STATE <b>Md</b>			13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>TOWSON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>313 LENNOX AVE.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Smith</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Johnson</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				
16b. SOCIAL SECURITY NO. <b>212-03-2828</b>			17. INFORMANT ADDRESS <b>Mrs. Edith Smith 313 LENNOX AVE MD.</b>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of prostate</b> <b>185-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Mar. 3</b> 19 <b>80</b> , to <b>Mar. 3</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>Mar. 3</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.										
22b. SIGNATURE <b>R. Sirota MD</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3-3-80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ronald L. Sirota, M.D.</b>						22e. ADDRESS <b>6701 N. Charles St. Towson, MD. 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/7/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Rest Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Towson Balto Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Chatman F.H. 1701 McCulloh St</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 4 1980</b>		25b. REGISTRAR'S SIGNATURE <b>R. Sirota</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
CERTIFICATE OF DEATH											
FOR 1. STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR DAY MIN	
Edgar		S.		Smith				03/31/80		4:50p	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
Male		White		Jan. 8, 1909		71					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto., Md. City MD.					
West Virginia		United States									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Johns Hopkins Hospital				Seaman		Merchant-Seaman			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		-		Baltimore		YES		1002 Evans Way			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
William - Smith											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
				579-03-4073		George W. Smith Rt. Box 83 / Catlett, Virginia					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>cardiac failure</u>										<u>minutes</u>	
5188 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										2wk	
(b) <u>pulmonary failure</u>											
(c) <u>lung disease of unclear etiology</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>adenocarcinoma of lungs</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/31</u> 19 <u>80</u> , to <u>3/31</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>3/31</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Martha Zeller</u>				DEGREE				22c. DATE SIGNED <u>3/31/80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. L. EIKS</u>				22e. ADDRESS <u>Johns Hopkins, Baltimore</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		4-5-80		Mt. Carmel Cemetery		Baltimore		-		Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Lilly & Zeiler Inc. 1901 Eastern Ave./21231						APR 7 1980		<u>Martha Zeller</u>			

WILEY

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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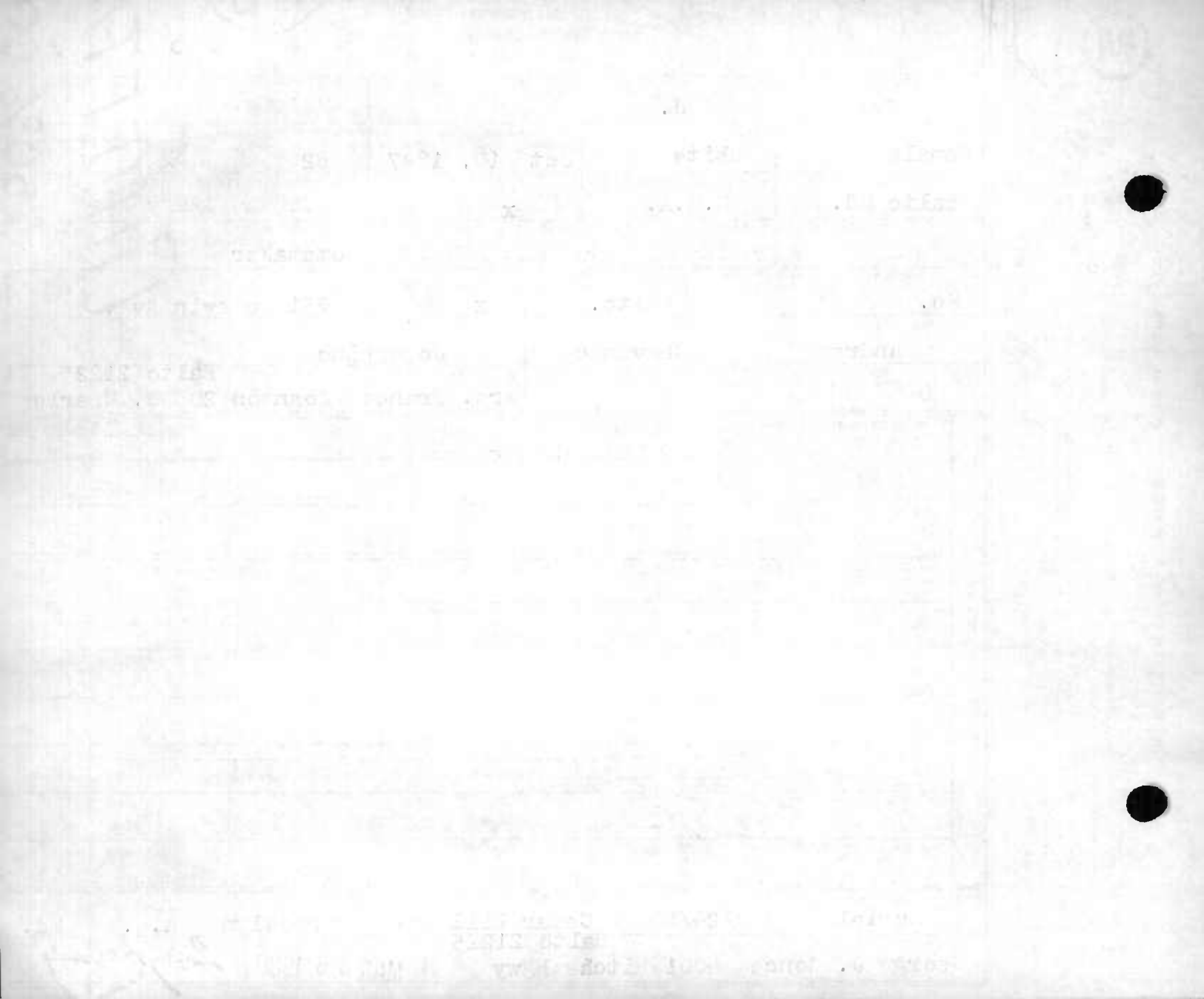
1. DECEASED NAME (TYPE OR PRINT) <b>Frances J. Smith</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3/20/80</b>		2b. HOUR <b>9:50A</b> M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct 10, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Baltimore Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>751 McKewin Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Chovanec</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Balto 21225 St</b> <b>Mrs. Frances Johnson 208 E. Charles</b>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1570 Cardio Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of the head of the pancreas</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 months</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION <b>3/4/80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of the head of Pancreas</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2/27/80</b> 19____ to <b>3/20/80</b> 19____, that (I) (we) last saw the deceased alive on <b>3/20/80</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>S. Shafik</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/20/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. Shafik, M.D.</b>		22e. ADDRESS <b>GBMC, 6701 N. Charles St. Balto., 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/24/80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn A.A. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hgwy</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1980</b>	25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

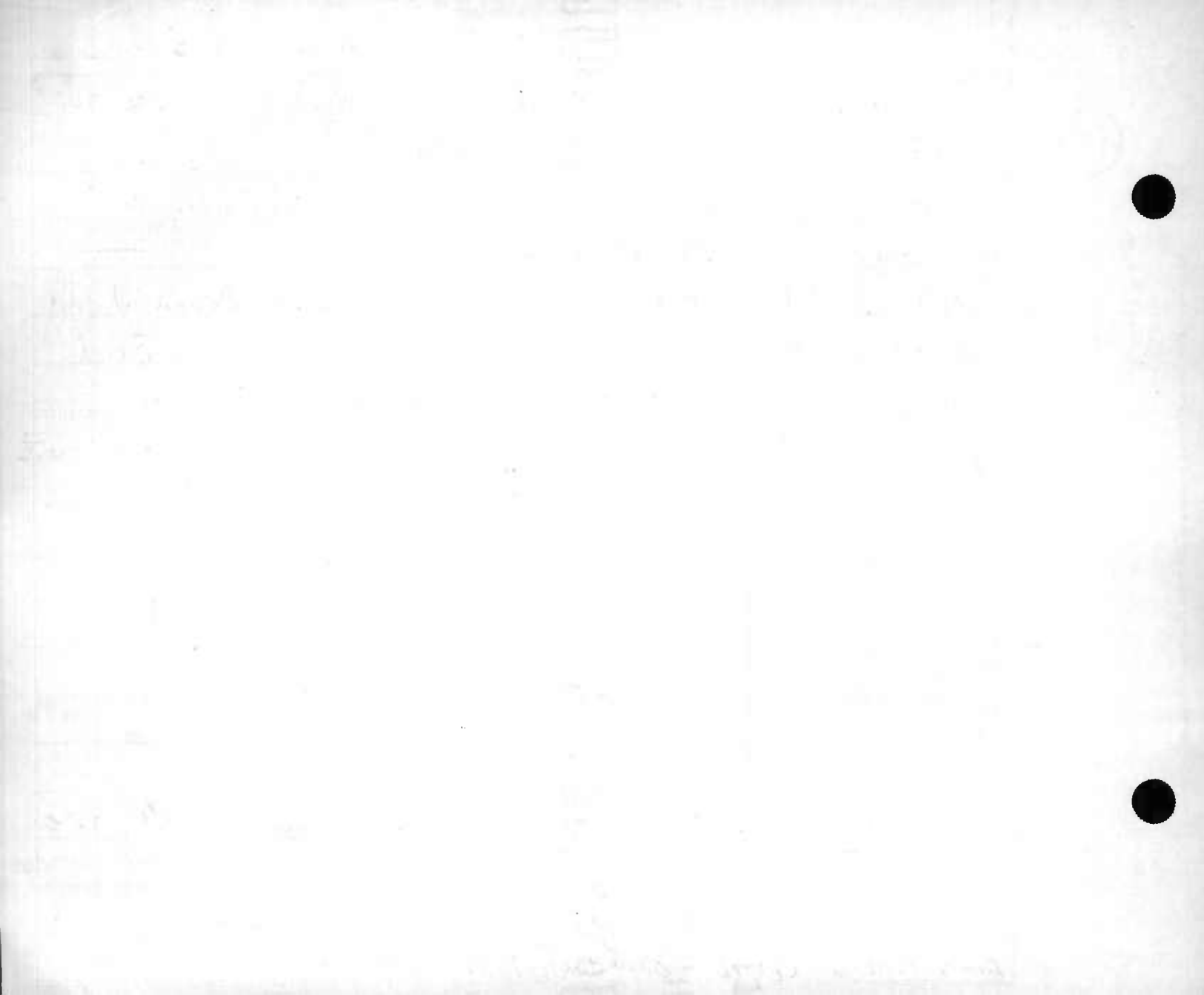


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 06228	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Heather E. Smith</b>				2a. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>16</b> YEAR <b>1980</b>		2b. HOUR <b>3:45</b> M			
3. SEX <b>F.</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>Dec</b> DAY <b>5</b> YEAR <b>1979</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS <b>3</b> DAYS <b>11</b>		IF UNDER 1 YEAR IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE, CO</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hillendale</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A CITY, GIVE STREET ADDRESS) <b>1398 DEANWOOD RD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>Hillendale</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1398 DEANWOOD RD</b>			
14. FATHER'S NAME FIRST <b>MARK</b> MIDDLE <b>H</b> LAST <b>SMITH</b>		15. MOTHER'S MAIDEN NAME FIRST <b>SHARON</b> MIDDLE <b>Y</b> LAST <b>BECK</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Family Records</b>		ADDRESS					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intercranial pressure</b>										<b>2 weeks</b>	
7410 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Thalamic neurocysticercosis</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hydrocephalus.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>3/6</b> , 19 <b>80</b> , to <b>death</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>3/12</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Anthony Perlman</b>		DEGREE <b>PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3/17/1980</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANTHONY PERLMAN</b>		22e. ADDRESS <b>204 E JOPPA ROAD BALTO MD 21204</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/18/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION CITY OR TOWN <b>BALTO</b> COUNTY <b>MD</b>					
24. FUNERAL DIRECTOR'S NAME <b>EVANS FUNERAL Chapel</b>		ADDRESS <b>8800 HARTFORD RD</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony Perlman</b>					





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

0 6 2 2 9

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Leone N. Smith</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>March 1, 1980</b>		2b. HOUR <b>2</b> P M	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>June 28, 1888</b>	
6 AGE (IN YEARS LAST BIRTHDAY) <b>91</b>		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10 CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1927 Rockwell Ave.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Trumbull Co.</b>		13a. STREET ADDRESS <b>1927 Rockwell Avenue 21228</b>		13b. CITY OR TOWN <b>Catonsville</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>John Baum</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Shugars</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>297-40-0012</b>		17. INFORMANT ADDRESS <b>Alan Smith 1927 Rockwell Ave. 21228</b>			

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>H. A. S. H. D.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>Years</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/13/1978</b> to <b>March 1, 1980</b> , that (I) (we) lost saw the deceased alive on <b>1/25/1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Adnan M. Sonmez</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/2/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Adnan M. Sonmez</b>				22e. ADDRESS <b>500 N. Rolling Rd. Catonsville, Md.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/5/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakwood</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Warren Ohio</b>	
24 FUNERAL DIRECTOR NAME ADDRESS <b>WITZKE FUNERAL HOME OF CATONSVILLE 1630 Edmondson Ave. Baltimore Md. 21228</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 4 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Forney</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 06230				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LEWIS E. SMITH</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 13, 1980</b>			2b. HOUR <b>5:50 am</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11-9-1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SAINT JOSEPH HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PLUMBER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PLUMBING</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>BALTO</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2908 LINGANORE AVE.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT SMITH</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CECILIA PERTZ</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>W-W-I.</b>		17. INFORMANT <b>Mary K. Smith</b>		ADDRESS <b>2908 Linganore Ave</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4254 Congestive cardiomyopathy and heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Carcinoma of the bladder by history</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <b>X</b> (this hospital) attended the deceased from <b>March 6</b> , 19 <b>80</b> , to <b>March 13</b> , 19 <b>80</b> , that <b>X</b> (we) lost saw the deceased alive on <b>March 13</b> , 19 <b>80</b> , and that in <b>X</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>X</b> (we) (did) (not) view the body after death.									
22b. SIGNATURE <b>A.H. Ghiladi</b>					DEGREE <b>MD.</b>		22c. DATE SIGNED <b>March 13, 1980</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A.H. GHILADI, MD.</b>					22e. ADDRESS <b>7600 OSLER DR. TOWSON 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3-17-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>			
24. FUNERAL DIRECTOR NAME <b>Stanley Miller</b>					ADDRESS <b>7527 Harford Rd</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 17 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McBrady</b>

1. NAME OF LAND		2. LOCATION	
3. ACRES		4. DATE	
5. COUNTY		6. STATE	
7. TOWNSHIP		8. RANGE	
9. SECTION		10. QUARTER	
11. SURVEY		12. MONUMENTS	
13. ADJACENT LANDS		14. REMARKS	
15. SIGNATURE		16. TITLE	
17. DATE		18. OFFICE	
19. COUNTY		20. STATE	
21. TOWNSHIP		22. RANGE	
23. SECTION		24. QUARTER	
25. SURVEY		26. MONUMENTS	
27. ADJACENT LANDS		28. REMARKS	
29. SIGNATURE		30. TITLE	
31. DATE		32. OFFICE	
33. COUNTY		34. STATE	
35. TOWNSHIP		36. RANGE	
37. SECTION		38. QUARTER	
39. SURVEY		40. MONUMENTS	
41. ADJACENT LANDS		42. REMARKS	
43. SIGNATURE		44. TITLE	
45. DATE		46. OFFICE	
47. COUNTY		48. STATE	
49. TOWNSHIP		50. RANGE	
51. SECTION		52. QUARTER	
53. SURVEY		54. MONUMENTS	
55. ADJACENT LANDS		56. REMARKS	
57. SIGNATURE		58. TITLE	
59. DATE		60. OFFICE	
61. COUNTY		62. STATE	
63. TOWNSHIP		64. RANGE	
65. SECTION		66. QUARTER	
67. SURVEY		68. MONUMENTS	
69. ADJACENT LANDS		70. REMARKS	
71. SIGNATURE		72. TITLE	
73. DATE		74. OFFICE	
75. COUNTY		76. STATE	
77. TOWNSHIP		78. RANGE	
79. SECTION		80. QUARTER	
81. SURVEY		82. MONUMENTS	
83. ADJACENT LANDS		84. REMARKS	
85. SIGNATURE		86. TITLE	
87. DATE		88. OFFICE	
89. COUNTY		90. STATE	
91. TOWNSHIP		92. RANGE	
93. SECTION		94. QUARTER	
95. SURVEY		96. MONUMENTS	
97. ADJACENT LANDS		98. REMARKS	
99. SIGNATURE		100. TITLE	
101. DATE		102. OFFICE	
103. COUNTY		104. STATE	
105. TOWNSHIP		106. RANGE	
107. SECTION		108. QUARTER	
109. SURVEY		110. MONUMENTS	
111. ADJACENT LANDS		112. REMARKS	
113. SIGNATURE		114. TITLE	
115. DATE		116. OFFICE	
117. COUNTY		118. STATE	
119. TOWNSHIP		120. RANGE	
121. SECTION		122. QUARTER	
123. SURVEY		124. MONUMENTS	
125. ADJACENT LANDS		126. REMARKS	
127. SIGNATURE		128. TITLE	
129. DATE		130. OFFICE	
131. COUNTY		132. STATE	
133. TOWNSHIP		134. RANGE	
135. SECTION		136. QUARTER	
137. SURVEY		138. MONUMENTS	
139. ADJACENT LANDS		140. REMARKS	
141. SIGNATURE		142. TITLE	
143. DATE		144. OFFICE	
145. COUNTY		146. STATE	
147. TOWNSHIP		148. RANGE	
149. SECTION		150. QUARTER	
151. SURVEY		152. MONUMENTS	
153. ADJACENT LANDS		154. REMARKS	
155. SIGNATURE		156. TITLE	
157. DATE		158. OFFICE	
159. COUNTY		160. STATE	
161. TOWNSHIP		162. RANGE	
163. SECTION		164. QUARTER	
165. SURVEY		166. MONUMENTS	
167. ADJACENT LANDS		168. REMARKS	
169. SIGNATURE		170. TITLE	
171. DATE		172. OFFICE	
173. COUNTY		174. STATE	
175. TOWNSHIP		176. RANGE	
177. SECTION		178. QUARTER	
179. SURVEY		180. MONUMENTS	
181. ADJACENT LANDS		182. REMARKS	
183. SIGNATURE		184. TITLE	
185. DATE		186. OFFICE	
187. COUNTY		188. STATE	
189. TOWNSHIP		190. RANGE	
191. SECTION		192. QUARTER	
193. SURVEY		194. MONUMENTS	
195. ADJACENT LANDS		196. REMARKS	
197. SIGNATURE		198. TITLE	
199. DATE		200. OFFICE	
201. COUNTY		202. STATE	
203. TOWNSHIP		204. RANGE	
205. SECTION		206. QUARTER	
207. SURVEY		208. MONUMENTS	
209. ADJACENT LANDS		210. REMARKS	
211. SIGNATURE		212. TITLE	
213. DATE		214. OFFICE	
215. COUNTY		216. STATE	
217. TOWNSHIP		218. RANGE	
219. SECTION		220. QUARTER	
221. SURVEY		222. MONUMENTS	
223. ADJACENT LANDS		224. REMARKS	
225. SIGNATURE		226. TITLE	
227. DATE		228. OFFICE	
229. COUNTY		230. STATE	
231. TOWNSHIP		232. RANGE	
233. SECTION		234. QUARTER	
235. SURVEY		236. MONUMENTS	
237. ADJACENT LANDS		238. REMARKS	
239. SIGNATURE		240. TITLE	
241. DATE		242. OFFICE	
243. COUNTY		244. STATE	
245. TOWNSHIP		246. RANGE	
247. SECTION		248. QUARTER	
249. SURVEY		250. MONUMENTS	
251. ADJACENT LANDS		252. REMARKS	
253. SIGNATURE		254. TITLE	
255. DATE		256. OFFICE	
257. COUNTY		258. STATE	
259. TOWNSHIP		260. RANGE	
261. SECTION		262. QUARTER	
263. SURVEY		264. MONUMENTS	
265. ADJACENT LANDS		266. REMARKS	
267. SIGNATURE		268. TITLE	
269. DATE		270. OFFICE	
271. COUNTY		272. STATE	
273. TOWNSHIP		274. RANGE	
275. SECTION		276. QUARTER	
277. SURVEY		278. MONUMENTS	
279. ADJACENT LANDS		280. REMARKS	
281. SIGNATURE		282. TITLE	
283. DATE		284. OFFICE	
285. COUNTY		286. STATE	
287. TOWNSHIP		288. RANGE	
289. SECTION		290. QUARTER	
291. SURVEY		292. MONUMENTS	
293. ADJACENT LANDS		294. REMARKS	
295. SIGNATURE		296. TITLE	
297. DATE		298. OFFICE	
299. COUNTY		300. STATE	
301. TOWNSHIP		302. RANGE	
303. SECTION		304. QUARTER	
305. SURVEY		306. MONUMENTS	
307. ADJACENT LANDS		308. REMARKS	
309. SIGNATURE		310. TITLE	
311. DATE		312. OFFICE	
313. COUNTY		314. STATE	
315. TOWNSHIP		316. RANGE	
317. SECTION		318. QUARTER	
319. SURVEY		320. MONUMENTS	
321. ADJACENT LANDS		322. REMARKS	
323. SIGNATURE		324. TITLE	
325. DATE		326. OFFICE	
327. COUNTY		328. STATE	
329. TOWNSHIP		330. RANGE	
331. SECTION		332. QUARTER	
333. SURVEY		334. MONUMENTS	
335. ADJACENT LANDS		336. REMARKS	
337. SIGNATURE		338. TITLE	
339. DATE		340. OFFICE	
341. COUNTY		342. STATE	
343. TOWNSHIP		344. RANGE	
345. SECTION		346. QUARTER	
347. SURVEY		348. MONUMENTS	
349. ADJACENT LANDS		350. REMARKS	
351. SIGNATURE		352. TITLE	
353. DATE		354. OFFICE	
355. COUNTY		356. STATE	
357. TOWNSHIP		358. RANGE	
359. SECTION		360. QUARTER	
361. SURVEY		362. MONUMENTS	
363. ADJACENT LANDS		364. REMARKS	
365. SIGNATURE		366. TITLE	
367. DATE		368. OFFICE	
369. COUNTY		370. STATE	
371. TOWNSHIP		372. RANGE	
373. SECTION		374. QUARTER	
375. SURVEY		376. MONUMENTS	
377. ADJACENT LANDS		378. REMARKS	
379. SIGNATURE		380. TITLE	
381. DATE		382. OFFICE	
383. COUNTY		384. STATE	
385. TOWNSHIP		386. RANGE	
387. SECTION		388. QUARTER	
389. SURVEY		390. MONUMENTS	
391. ADJACENT LANDS		392. REMARKS	
393. SIGNATURE		394. TITLE	
395. DATE		396. OFFICE	
397. COUNTY		398. STATE	
399. TOWNSHIP		400. RANGE	
401. SECTION		402. QUARTER	
403. SURVEY		404. MONUMENTS	
405. ADJACENT LANDS		406. REMARKS	
407. SIGNATURE		408. TITLE	
409. DATE		410. OFFICE	
411. COUNTY		412. STATE	
413. TOWNSHIP		414. RANGE	
415. SECTION		416. QUARTER	
417. SURVEY		418. MONUMENTS	
419. ADJACENT LANDS		420. REMARKS	
421. SIGNATURE		422. TITLE	
423. DATE		424. OFFICE	
425. COUNTY		426. STATE	
427. TOWNSHIP		428. RANGE	
429. SECTION		430. QUARTER	
431. SURVEY		432. MONUMENTS	
433. ADJACENT LANDS		434. REMARKS	
435. SIGNATURE		436. TITLE	
437. DATE		438. OFFICE	
439. COUNTY		440. STATE	
441. TOWNSHIP		442. RANGE	
443. SECTION		444. QUARTER	
445. SURVEY		446. MONUMENTS	
447. ADJACENT LANDS		448. REMARKS	
449. SIGNATURE		450. TITLE	
451. DATE		452. OFFICE	
453. COUNTY		454. STATE	
455. TOWNSHIP		456. RANGE	
457. SECTION		458. QUARTER	
459. SURVEY		460. MONUMENTS	
461. ADJACENT LANDS		462. REMARKS	
463. SIGNATURE		464. TITLE	
465. DATE		466. OFFICE	
467. COUNTY		468. STATE	
469. TOWNSHIP		470. RANGE	
471. SECTION		472. QUARTER	
473. SURVEY		474. MONUMENTS	
475. ADJACENT LANDS		476. REMARKS	
477. SIGNATURE		478. TITLE	
479. DATE		480. OFFICE	
481. COUNTY		482. STATE	
483. TOWNSHIP		484. RANGE	
485. SECTION		486. QUARTER	
487. SURVEY		488. MONUMENTS	
489. ADJACENT LANDS		490. REMARKS	
491. SIGNATURE		492. TITLE	
493. DATE		494. OFFICE	
495. COUNTY		496. STATE	
497. TOWNSHIP		498. RANGE	
499. SECTION		500. QUARTER	
501. SURVEY		502. MONUMENTS	
503. ADJACENT LANDS		504. REMARKS	
505. SIGNATURE		506. TITLE	
507. DATE		508. OFFICE	
509. COUNTY		510. STATE	
511. TOWNSHIP		512. RANGE	
513. SECTION		514. QUARTER	
515. SURVEY		516. MONUMENTS	
517. ADJACENT LANDS		518. REMARKS	
519. SIGNATURE		520. TITLE	
521. DATE		522. OFFICE	
523. COUNTY		524. STATE	
525. TOWNSHIP		526. RANGE	
527. SECTION		528. QUARTER	
529. SURVEY		530. MONUMENTS	
531. ADJACENT LANDS		532. REMARKS	
533. SIGNATURE		534. TITLE	
535. DATE		536. OFFICE	
537. COUNTY		538. STATE	
539. TOWNSHIP		540. RANGE	
541. SECTION		542. QUARTER	
543. SURVEY		544. MONUMENTS	
545. ADJACENT LANDS		546. REMARKS	
547. SIGNATURE		548. TITLE	
549. DATE		550. OFFICE	
551. COUNTY		552. STATE	
553. TOWNSHIP		554. RANGE	
555. SECTION		556. QUARTER	
557. SURVEY		558. MONUMENTS	
559. ADJACENT LANDS		560. REMARKS	
561. SIGNATURE		562. TITLE	
563. DATE		564. OFFICE	
565. COUNTY		566. STATE	
567. TOWNSHIP		568. RANGE	
569. SECTION		570. QUARTER	
571. SURVEY		572. MONUMENTS	
573. ADJACENT LANDS		574. REMARKS	
575. SIGNATURE		576. TITLE	
577. DATE		578. OFFICE	
579. COUNTY		580. STATE	
581. TOWNSHIP		582. RANGE	
583. SECTION		584. QUARTER	
585. SURVEY		586. MONUMENTS	
587. ADJACENT LANDS		588. REMARKS	
589. SIGNATURE		590. TITLE	
591. DATE		592. OFFICE	
593. COUNTY		594. STATE	
595. TOWNSHIP		596. RANGE	
597. SECTION		598. QUARTER	
599. SURVEY		600. MONUMENTS	
601. ADJACENT LANDS		602. REMARKS	
603. SIGNATURE		604. TITLE	
605. DATE		606. OFFICE	
607. COUNTY		608. STATE	
609. TOWNSHIP		610. RANGE	
611. SECTION		612. QUARTER	
613. SURVEY		614. MONUMENTS	
615. ADJACENT LANDS		616. REMARKS	
617. SIGNATURE		618. TITLE	
619. DATE		620. OFFICE	
621. COUNTY		622. STATE	
623. TOWNSHIP		624. RANGE	
625. SECTION		626. QUARTER	
627. SURVEY		628. MONUMENTS	
629. ADJACENT LANDS		630. REMARKS	
631. SIGNATURE		632. TITLE	
633. DATE		634. OFFICE	
635. COUNTY		636. STATE	
637. TOWNSHIP		638. RANGE	
639. SECTION		640. QUARTER	
641. SURVEY		642. MONUMENTS	
643. ADJACENT LANDS		644. REMARKS	
645. SIGNATURE		646. TITLE	
647. DATE		648. OFFICE	
649. COUNTY		650. STATE	
651. TOWNSHIP		652. RANGE	
653. SECTION		654. QUARTER	
655. SURVEY		656. MONUMENTS	
657. ADJACENT LANDS		658. REMARKS	
659. SIGNATURE		660. TITLE	
661. DATE		662. OFFICE	
663. COUNTY		664. STATE	
665. TOWNSHIP		666. RANGE	
667. SECTION		668. QUARTER	
669. SURVEY		670. MONUMENTS	
671. ADJACENT LANDS		672. REMARKS	
673. SIGNATURE		674. TITLE	
675. DATE		676. OFFICE	
677. COUNTY		678. STATE	
679. TOWNSHIP		680. RANGE	
681. SECTION		682. QUARTER	
683. SURVEY		684. MONUMENTS	
685. ADJACENT LANDS		686. REMARKS	
687. SIGNATURE		688. TITLE	
689. DATE		690. OFFICE	
691. COUNTY		692. STATE	
693. TOWNSHIP		694. RANGE	
695. SECTION		696. QUARTER	
697. SURVEY		698. MONUMENTS	
699. ADJACENT LANDS		700. REMARKS	
701. SIGNATURE		702. TITLE	
703. DATE		704. OFFICE	
705. COUNTY		706. STATE	
707. TOWNSHIP		708. RANGE	
709. SECTION		710. QUARTER	
711. SURVEY		712. MONUMENTS	
713. ADJACENT LANDS		714. REMARKS	
715. SIGNATURE		716. TITLE	
717. DATE		718. OFFICE	
719. COUNTY		720. STATE	
721. TOWNSHIP		722. RANGE	
723. SECTION		724. QUARTER	
725. SURVEY		726. MONUMENTS	
727. ADJACENT LANDS		728. REMARKS	
729. SIGNATURE		730. TITLE	
731. DATE		732. OFFICE	
733. COUNTY		734. STATE	
735. TOWNSHIP		736. RANGE	
737. SECTION		738. QUARTER	
739. SURVEY		740. MONUMENTS	
741. ADJACENT LANDS		742. REMARKS	
743. SIGNATURE		744. TITLE	
745. DATE		746. OFFICE	
747. COUNTY		748. STATE	
749. TOWNSHIP		750. RANGE	
751. SECTION		752. QUARTER	
753. SURVEY		754. MONUMENTS	
755. ADJACENT LANDS		756. REMARKS	
757. SIGNATURE		758. TITLE	
759. DATE		760. OFFICE	
761. COUNTY		762. STATE	
7			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																										
1. FOR STATE REGISTRAR			REG. NO.																							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH			DAY			YEAR			2b. HOUR		
Marian			D.			Snead			3/4/80												9:15A M					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS											
Female			White			12 11 09			70			YRS			MONTHS			DAYS			HOURS			MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH																	
Virginia			U.S.A.						Baltimore County MD.																	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Towson			Greater Baltimore Medical Center												Sales Clerk			Hecht Co.								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS								
										Maryland		Baltimore		Woodlawn		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6511 Liberty Road		21207						
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																					
FIRST MIDDLE LAST					FIRST MIDDLE LAST																					
David W. Abbott					Louise Sturey																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS											
No					---					217-26-1341					Hilbert H. Snead 6511 Liberty Rd. 21207											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																										
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lymphoma																										
2038																										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																										
DUE TO, OR AS A CONSEQUENCE OF (b)																										
DUE TO, OR AS A CONSEQUENCE OF (c)																										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																		
				P.M. 19																						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN				COUNTY				STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2/15/80, 19____, to 3/4/80, 19____, that (I) (we) last saw the deceased alive on 3/4/80, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																										
22b. SIGNATURE										DEGREE				22c. DATE SIGNED												
S.P. Girdhar														3/4/80												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS																
S.P. Girdhar, M.D.										GBMC, 6701 N. Charles St. Baltimore 21204																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN				COUNTY				STATE						
BURIAL				3/7/80				Meadowridge Mem Pk				Elkridge				Howard				Md.						
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE												
HUBBARD FUNERAL HOME 4107 WILKINS AVE. 21229										MAR 6 1980				Anthony McCready												

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 number retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 0 0 6 2 3 2				REG. NO.					
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
LEO		K		SNYDER		Jr.		3 26 80		10 20 AM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		White		March 30, 1897		82					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U. S. A.				<del>XXXXXX</del> Balto. County					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON		509 E JOPPA RD MANOR CARE						Salesman		Appliance's	
13a. STATE										13b. CITY OR TOWN	
Maryland										Baltimore	
14 FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Leo K. Snyder, Sr.										Dorothea Weber	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS							
YES		WWI		577-03-5644		Mrs Caroline G. Snyder, Same As #13e					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Cardiovascular disease</i>										5 YRS	
(c) <i>Chronic Obstructive Lung Disease</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Chronic Obstructive Lung Disease</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (my hospital) attended the deceased from <i>15 January 1980</i> to <i>26 March 1980</i> , that (I) <i>did</i> lost saw the deceased alive on <i>26 March 1980</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>did</i> (did not) view the body after death.											
22b. SIGNATURE <i>Walter T. Kees</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>26 March 1980</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>WALTER T. KEES</i>		22e. ADDRESS <i>Towson Md 21204</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3-29-80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gardens Of Faith Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Balto. Maryland</i>					
24 FUNERAL DIRECTOR NAME <i>Ruck Towson Funeral Home, Inc.</i>		ADDRESS <i>1050 York Rd. Towson, Md. 21204</i>		25a. DATE REC'D BY REGISTRAR <i>MAR 28 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Anthony McCready</i>					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 0 6 2 3 3			
1- DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH				2b HOUR			
George E. SPEALMAN				3-10-80				1069 M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		May 23, 1910		69 YRS		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore County MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Randallstown		Balto. County Gen. Hospital						Farmer			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b COUNTY				13c CITY OR TOWN			
Maryland				Balto.				Randallstown			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME				16a ADDRESS			
George E. Spealman				Nettie Crist				Mr. Bruce E. Spealman 21133			
16b WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO				17 INFORMANT			
No				217-22-0601				10220 Liberty Road Randallstown, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure - 2										?	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiomyopathy											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR P.M. 19							
21d INJURY OCCURRED				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION			
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK								STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 3-9-80 to 3-10-80, that (I) (we) lost saw the deceased alive on 3-10-80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE				DEGREE				22c DATE SIGNED			
A.H. Ghiladi								3-10-80			
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS							
A.H. GHILADI, M.D.				7600 OSLER Dr. Towson 21204							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)				23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION			
Burial				3/13/80		Mt. Olive Cem.		Randallstown, Balto. MD.			
24 FUNERAL DIRECTOR				25 DATE REC'D. BY REGISTRAR				25b RECEIVED BY			
Loring Byers Funeral Directors				MAR 11 1980				[Signature]			
8728 Liberty Road Randallstown, Maryland											

29 JAN 1950

E

George

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Items 7a, 8 g541 3/27/80 gj

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

0 6 2 3 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter John SPERL SR.			2a. DATE OF DEATH MONTH DAY YEAR 3 10 80			2b. HOUR a 11:12 m			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb 23 1914		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN Sq. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Beer	
13a. STATE Md		13b. COUNTY BALTO		13c. CITY OR TOWN CARNY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3027 EAST AVE	
14. FATHER'S NAME FIRST MIDDLE LAST John SPERL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE E. HARPLE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-09-6919		17. INFORMANT ADDRESS Family Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410 - <u>ASPHEN - Acute MTC</u> DUE TO, OR AS A CONSEQUENCE OF <u>arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetic Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> , 19 <u>52</u> , to <u>March 10</u> , 19 <u>80</u> , that (I) (we) saw the deceased alive on <u>above</u> , (I) (we) (did) (did not) view the body after death, 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <u>Donald W. Minizer M.D.</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/12/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD W. MINIZER M.D.		22e. ADDRESS 3009 EVERGREEN AVE							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/13/80		23c. NAME OF CEMETERY OR CREMATOR MOUNTAIN CREST BURIAL		23d. LOCATION CITY OR TOWN Joppa HARTFORD MD		23e. DATE RECEIVED BY REGISTRAR MAR 13 1980	
24. FUNERAL DIRECTOR NAME EVANS FUNERAL Chapel 8800 HARTFORD RD									



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M  
(VR A15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06235

1. DECEASED-NAME (Type or print) <b>Henry F. Spiegel</b>			2a. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>1980</b>			2b. HOUR <b>11:50P M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 14, 1909</b>		6. AGE (In years last birthday) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto. Co.</b> Md.			
10. CITY OR TOWN OF DEATH <b>Westview Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>928 Bardswell Rd.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Baker A R S Co.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Westview Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>928 Bardswell Rd.</b>	
14. FATHER'S NAME First <b>Frederick</b> Middle <b>Spiegel</b> Last <b>Hilma</b>			15. MOTHER'S MAIDEN NAME First <b>Hilma</b> Middle <b>Spiegel</b> Last <b>Spiegel</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>217 03 1292</b>		17. INFORMANT <b>Mr. Paul F. Spiegel</b>		Address <b>Balto. Md. 21228</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardio-respiratory failure</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of lung &amp; metastases</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>To axilla &amp; supraclavicular nodes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION <b>13 March 80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bopsy of glands</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>10 March, 1980</b> to <b>17 March, 1980</b> , that (I) (we) last saw the deceased alive on <b>17 March 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>William J. Bryson M.D.</b>		DEGREE <b>M D</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>17 March 80</b>			
22d. PHYSICIAN'S NAME (Type) <b>J. M. S. BRYSON</b>		22e. ADDRESS <b>5712 Westview Mall. Balto. Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 21, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn Balto. Md.</b>			
24. FUNERAL DIRECTOR <b>G. Truman Schwab</b>				ADDRESS <b>5151 Balto. National Pike Balto. Md. 21229</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 26 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffrey McCrudy</b>	

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report body.]

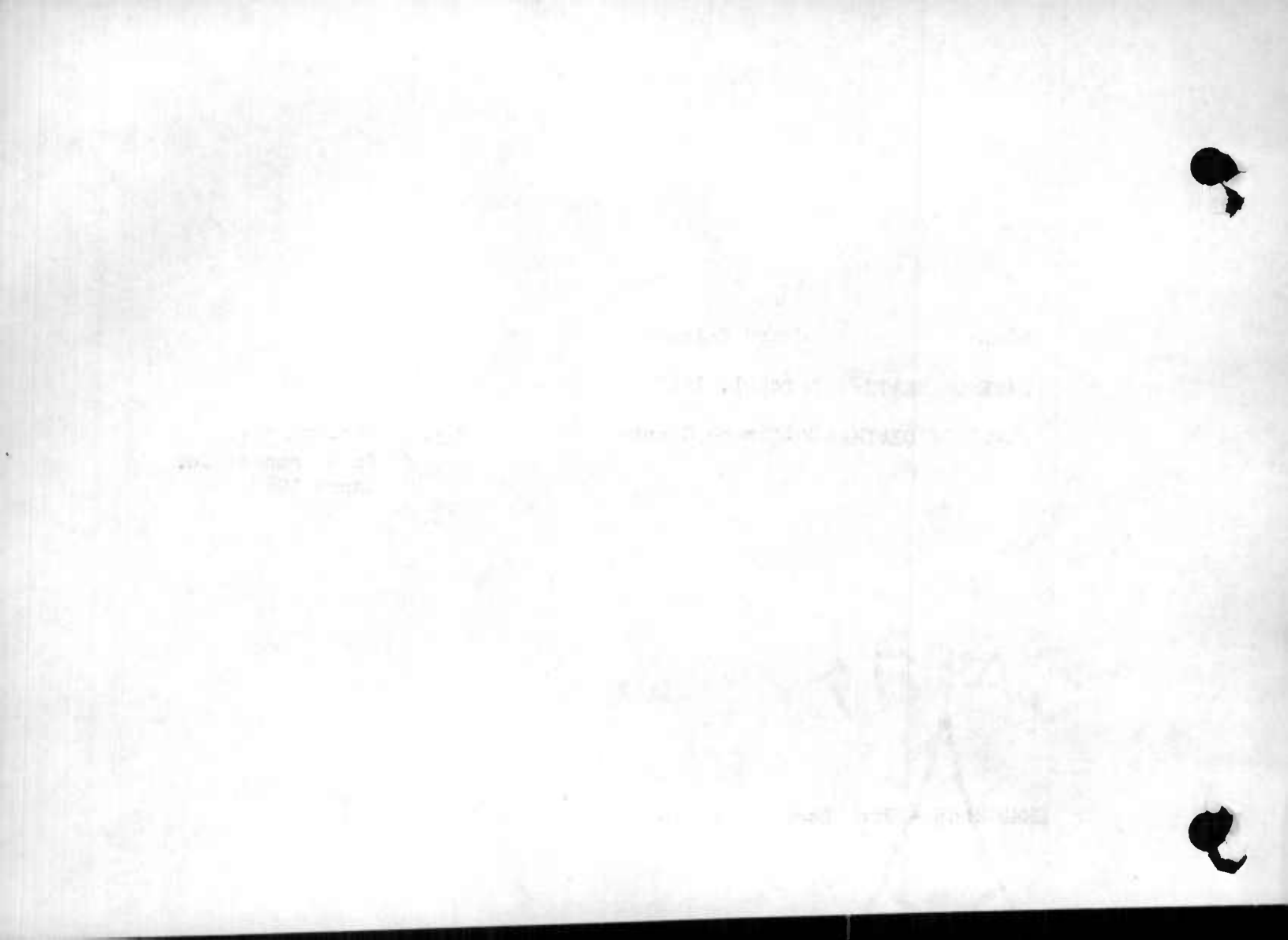
DATE: [Illegible]  
BY: [Illegible]  
[Illegible text at the bottom of the page, possibly a signature block or distribution list.]



**NAME:** Edward Spinney  
**DATE OF DEATH:** March 1, 1980  
**PLACE OF DEATH:** Baltimore County

**SEE:** #80-05825  
Anne Arundel Co.  
March 1980

DMH 2485 - Vit. Rec.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 0 6 2 3 6									
1. FOR STATE REGISTRAR		REG. NO.																	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
CHARLES		SPRIGGS						3				26		1980		2-15 P.M.			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	
Male		white		9 15 04		75		Md.		U.S.A.				Baltimore Co.		Randallstown		Baltimore Co. General Hosp.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17 INFORMANT	
Laborer		Textile		Md.		Allegany		Westernport		Charles		Beulah		No		216-07-2582		Richard Spriggs	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. INJURY OCCURRED		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		22a. SIGNATURE		22b. DATE SIGNED	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u>						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. INJURY OCCURRED		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		22a. SIGNATURE		22b. DATE SIGNED	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CVA</u>						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. INJURY OCCURRED		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		22a. SIGNATURE		22b. DATE SIGNED	
DUE TO, OR AS A CONSEQUENCE OF (c)						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. INJURY OCCURRED		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		22a. SIGNATURE		22b. DATE SIGNED	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. INJURY OCCURRED		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		22a. SIGNATURE		22b. DATE SIGNED	
22. I certify that (I) (this hospital) attended the deceased from <u>3/22/80</u> 19 <u>80</u> , to <u>3/26/80</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>3/26/80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. INJURY OCCURRED		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		22a. SIGNATURE		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		24 FUNERAL DIRECTOR'S NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		26. I certify that (I) (this hospital) attended the deceased from <u>3/22/80</u> 19 <u>80</u> , to <u>3/26/80</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>3/26/80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		27a. SIGNATURE		27b. DATE SIGNED	
Burial		3/29/80		Philos Cem.		Westernport Allegany Md.		Boal Funeral Service P. A. Westernport Md.		APR 2 1980		Rickey McCreedy							

BP



Handwritten text, mostly illegible due to blurriness and bleed-through. Visible fragments include:

- Top left: "3 2 1 1941 2 1 1"
- Top center: "3 2 1 1941 2 1 1"
- Top right: "3 2 1 1941 2 1 1"
- Middle left: "3 2 1 1941 2 1 1"
- Middle center: "3 2 1 1941 2 1 1"
- Middle right: "3 2 1 1941 2 1 1"
- Bottom left: "3 2 1 1941 2 1 1"
- Bottom center: "3 2 1 1941 2 1 1"
- Bottom right: "3 2 1 1941 2 1 1"

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8006237					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Albert Gilmore Stambaugh				3/28/80				9:40A M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept. 13, 1930		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 49		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7c. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Reg. Salesman		12b. KIND OF BUSINESS OR INDUSTRY Brewing	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Timonium	
				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1814 Reuter Road			
14. FATHER'S NAME FIRST MIDDLE LAST Ernest Pleasant Stambaugh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lettie Viola Merson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 217-24-8848		17 INFORMANT ADDRESS Mrs. Mary Anna Stambaugh 1814 Reuter Rd. Timonium, Md 21093			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of lung with metastasis</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/27/80</u> , 19____, to <u>3/28/80</u> , 19____, that (I) (we) last saw the deceased alive on <u>3/28/80</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>W. Edwards, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3/28/80	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) W. Edwards, M.D.				22d. ADDRESS GBMC, 6701 N. Charles St. Baltimore 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/31/80		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto. Co., Md.			
24. FUNERAL DIRECTOR'S NAME Martin D. Lawson, 10W. Padonia Rd. Timonium				25. DATE REC'D. BY REGISTRAR MAR 31 1980					

Handwritten signature or name, possibly "A. B. ...".

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 6 2 3 8

1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>Dennis</b>	MIDDLE <b>Edward</b>	LAST <b>Stamper</b>	2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> 3 29 19 80		2b. HOUR M
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 30, 1967</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>12</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>3 29 19 80</b>	2d. HOUR M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rossville 21237</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>	13c. CITY OR TOWN <b>Middle River</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>8 Cowl Ct. 21220</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Dasil Edward Stamper</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laveta G. Testerman</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-88-1487</b>		17. INFORMANT <b>Laveta G. Stamper</b> ADDRESS <b>8 Cowl Court Baltimore, Md. 21220</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis</b> <b>4-2-90</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Hormez R. Guard</b>		TITLE (SPECIFY) <b>Assistant</b> M.D. MEDICAL EXAMINER				DATE SIGNED <b>3/30/80</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>		ADDRESS <b>111 Penn Street, Balto., MD 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-1-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Memorial Gard.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Bruzdzinski Funeral Home</b>		ADDRESS <b>PA 1407 Old Eastern Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 2 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Barney McCreedy</b>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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10.10 11.10 12.10 13.10 14.10 15.10 16.10 17.10 18.10 19.10 20.10 21.10 22.10 23.10 24.10 25.10 26.10 27.10 28.10 29.10 30.10 31.10

01.11 02.11 03.11 04.11 05.11 06.11 07.11 08.11 09.11 10.11 11.11 12.11 13.11 14.11 15.11 16.11 17.11 18.11 19.11 20.11 21.11 22.11 23.11 24.11 25.11 26.11 27.11 28.11 29.11 30.11 31.11

01.12 02.12 03.12 04.12 05.12 06.12 07.12 08.12 09.12 10.12 11.12 12.12 13.12 14.12 15.12 16.12 17.12 18.12 19.12 20.12 21.12 22.12 23.12 24.12 25.12 26.12 27.12 28.12 29.12 30.12 31.12

01.01 02.01 03.01 04.01 05.01 06.01 07.01 08.01 09.01 10.01 11.01 12.01 13.01 14.01 15.01 16.01 17.01 18.01 19.01 20.01 21.01 22.01 23.01 24.01 25.01 26.01 27.01 28.01 29.01 30.01 31.01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 0 6 2 3 9			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH									
I. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR					
JERRY LEE STANCILL III				MARCH 19, 1980				4:05 a					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		March 13, 1980		-- YRS - 6		MONTHS - 6		DAYS - 6			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				BALTIMORE COUNTY MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON		SAINT JOSEPH HOSPITAL						--		--			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Harford		Bel Air		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		202 Apt. D Fairwood Road			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Jerry Lee Stancill II				Mary Frances Kelly									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
no				none		Jerry L. Stancill II, Bel Air, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) ANOXIC ENCEPHALOPATHY													
3481 DUE TO, OR AS A CONSEQUENCE OF													
(b) _____													
DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR									
				P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from March 13, 1980, to March 19, 1980, that (I) (we) last saw the deceased alive on March 19, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
MAURICE FURLONG, JR.													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
				7620 York Road, Towson, MD 21204									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE			
Burial				Mar. 21, 1980		St. Mary's Cem.		Pylesville Harford		Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
NAME Howard K. McComas III, Abingdon, Md.				MAR 24 1980				[Signature]					

ANXIOUS ENCRYPHOTOGRAPHY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 0 6 2 4 0			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) <b>Lydia Mary Staszewski</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>March 19, 1980</b>				2b. HOUR <b>3:00 PM</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 28, 1910</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		7 UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		7 UNDER 24 HRS HOURS MIN. <b>0 0</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.							
10 CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tin Sorter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Edgemere</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2917 Delmar Ave. 21219</b>						
14 FATHER'S NAME FIRST MIDDLE LAST <b>Michael Meszaros</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bella Bore</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>219-12-7513</b>		17 INFORMANT ADDRESS <b>Mary Meszaros (same as line 13)</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1519 IMMEDIATE CAUSE (a). Cardio-Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gastric Carcinoma - Liver Metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Lung Metastasis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Respiratory Failure - Tracheostomy</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 14</b> 19 <b>80</b> to <b>March 19</b> 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>March 19</b> 19 <b>80</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.													
22b. SIGNATURE <b>David Moises</b>					DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3-19-80</b> P.M.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David Moises</b>					22e. ADDRESS <b>8000 Franklin Square Drive, Balto Md 21237</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/22/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>					
24 FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc., Baltimore, Maryland</b>					ADDRESS <b>Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 21 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Fitzgerald</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 0 0 6 2 4 1				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) REUBEN H. STEINBERG				2a. DATE OF DEATH MONTH DAY YEAR 3 30 1980				2b. HOUR PM 5:55 PM	
3. SEX M ALE		4. RACE W HITE		5. DATE OF BIRTH MONTH DAY YEAR 6 11 1908		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GR. BALTO. MED. CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTORNEY		12b. KIND OF BUSINESS OR INDUSTRY AT LAW	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MORRIS STEINBERG				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 213-38-9776		17. INFORMANT MRS. ANNE STEINBERG 4 POMONA NO., APT. #8 #21208					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CA DUE TO, OR AS A CONSEQUENCE OF (b) COLON CANCER DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Reuben H. Steinberg</i>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/30/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTURO FRIDMAN				22e. ADDRESS GBMC. 6701 N. CHARLES ST. 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAR. 31, 1980		23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO		23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTER TOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR APR 2 1980		25b. REGISTRAR'S SIGNATURE <i>History K. B...</i>			

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BALTIMORE COUNTY

ST. BALTO. MED. CENTER

BALTIMORE

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*Arthur F. H. H. D.*

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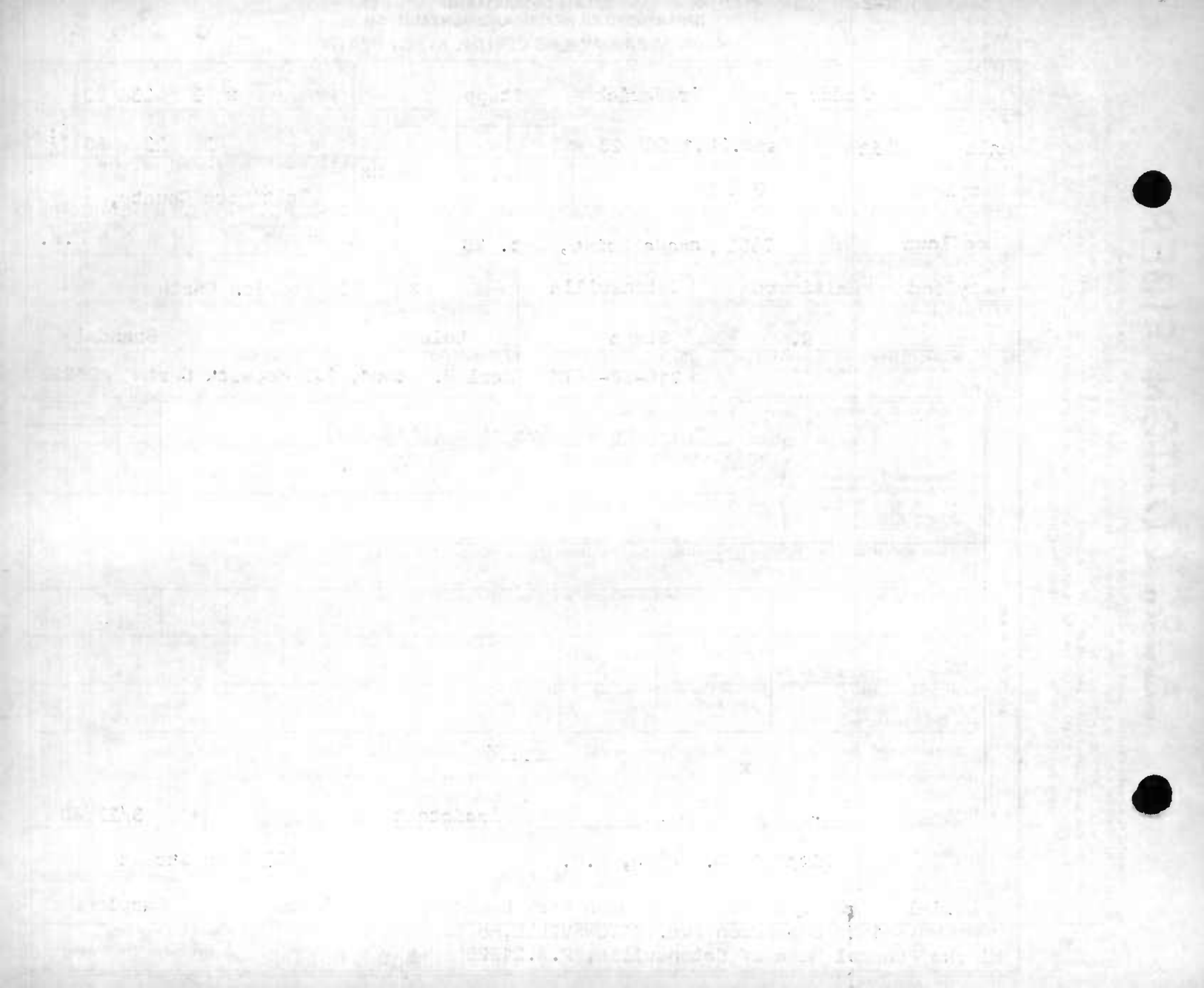
ARTHUR F. H. H. D.

1980



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06242	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jeffrey Frederick Stepp										2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 3 23 19 80	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 28, 1956	6. AGE (IN YEARS) (LAST BIRTHDAY) 23 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 3 23 19 80		2b. HOUR 24 HOUR 6:00 A M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD					
10. CITY OR TOWN OF DEATH Woodlawn		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7401 Lasada Drive, Apt. 2B				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brakeman		12b. KIND OF BUSINESS OR INDUSTRY B & O R.R.			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 233 Medwick Garth			
14. FATHER'S NAME FIRST MIDDLE LAST Karl R. Stepp				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lois Brandal							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-66-4673		17. INFORMANT ADDRESS Karl R. Stepp, 233 Medwick Garth 21228							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intravenous narcotism (Dilaudid)</u> 3044 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan		M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 3/23/80					
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.		ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/26/80		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME 1630 Edmondson Ave., CATONSVILLE, Md Witzke Funeral Home of Catonsville, P.A. 21228				25a. DATE REC'D. BY REGISTRAR MAR 26 1980		25b. REGISTRAR'S SIGNATURE Dorothy McCready					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARY</b>			FIRST MIDDLE LAST <b>STIELPER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 22, 1980</b>				2b. HOUR <b>M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 24 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GERMANY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. COUNTY</b> MD					
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>27 FUSTINGS AVE.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD.</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>27 FUSTINGS AVE.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>NIEPIERSKI</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>WIKAMENA SHILP.</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					
16b. SOCIAL SECURITY NO. <b>219-16-4495</b>			17. INFORMANT ADDRESS <b>2435 ANNST.</b> <b>GEORGE STIELPER</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Colic Aorta</b> <b>4149</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ACVD. CHF</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHF</b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>[Signature]</b> THE PHYSICIAN'S NAME (TYPE OR PRINT)						DEGREE <b>[Signature]</b>		ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/24/80</b>	
22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>3-25-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BLAND MD.</b>				
24. FUNERAL DIRECTOR NAME <b>JOHN M. WEBER. F. SANDS INC.</b> ADDRESS <b>401 S. CHESTER</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

10/24/11  
10/24/11

10/24/11

10/24/11

10/24/11

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHARITY A STOUT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 3 80</b>			2b. HOUR <b>5:30P</b>				
3 SEX <b>F</b>		4 RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 27 1875</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>104</b> YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>205 WESTOWNE RD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD</b>			13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>KATONSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>205 WESTOWNE RD</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ANDREW DUNCAN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>REBECCA HEAPS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>212-10-4803</b>			17. INFORMANT <b>DOROTHY KOHLBUS</b>			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>Semility</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b> <b>5 yrs</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <b>Mar. 2</b> , 19 <b>78</b> , to <b>Mar. 3</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>Feb. 29</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>A. Bradley Daugharthy MD</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-4-80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. Bradley Daugharthy, M.D.</b>						22e. ADDRESS <b>1864 FRANCIS AVE</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>3/7/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>WEBER FUNERAL HOME EDMONDSON AVE 5311</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

8



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 006245							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			2b. HOUR
MILTON C. STROTT						03 20 80			4:23P <sub>M</sub>
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Nov. 19, 1906		73 YRS.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				TOWSON			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		6701 N. CHARLES STREET GBMC				Printer			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		-		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
Charles		Catherine		No		213-05-5286		Grace Strott, wife, same address	
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE RESPIRATION FAILURE 1629 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) METASTATIC CARCINOMA (c) DUE TO, OR AS A CONSEQUENCE OF PRIMARY CARCINOMA OF THE LUNG APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HOURS 3 MONTHS 10 MONTHS								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 03/20 19 80 to 03/20 19 80, that (I) (we) lost saw the deceased alive on 03/20 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DR. GEORGE J. RICHARDS, JR.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 03/20/80	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR	
Burial		3/24/80		Baltimore Cemetery		Baltimore, Md.		MAR 24 1980	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
S. Muhlen Funeral Home, Inc.		331 Brehms Lane Balto., Md. 21211							



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BALTIMORE 1001 N. CHARLES ST. 2F

ACUTE RESPIRATORY FAILURE  
STATISTICAL CHRONIC  
PRIMARY OBSTRUCTION OF THE LUNG

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DR. GEORGE J. LICHNER, JR., DIRECTOR, BALTIMORE MEDICAL CENTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 06246	
1. DECEASED NAME (TYPE OR PRINT) Anne Elizabeth Stubenrauch			2a. DATE OF DEATH MONTH DAY YEAR March 1 1980			2b. HOUR 7:20 PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 7, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Rossville 21237		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Restaurant			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Essex 21221		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21221 219 S. Marlyn Ave. Apt. A		
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Chmielewski			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella Machinski								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 189-05-7414		17. INFORMANT Carl Stubenrauch, husband			ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> <u>4380</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Congestive Heart Failure, Cachexia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 15</u> 19 <u>80</u> to <u>March 1</u> 19 <u>80</u> , that (I/we) lost saw the deceased alive on <u>March 1</u> 19 <u>80</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) did not view the body after death.											
22b. SIGNATURE <u>[Signature]</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3-1-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Janardhanan Rayi			22e. ADDRESS 9000 Franklin Square Dr., 21237								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-5-80		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County Maryland				
24. FUNERAL DIRECTOR <u>[Signature]</u>			25a. DATE REC'D. BY REGISTRAR MAR 3 1980			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					
26. FUNERAL HOME Broudzinski Funeral Home PA 1407 Old Eastern Ave.											



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 6 2 4 7  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Sarah - SWEENEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 31, 1980</b>			2b. HOUR <b>11:00am</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 14, 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ireland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Patrick - Brogan</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ann - Clarke</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>214-74-0086</b>			17. INFORMANT ADDRESS <b>Mr. Patrick E. Sweeney 1735 Wadsworth Way</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, right lower lobe, extensive</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pleural effusion (3000 ml.)</b>			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 26</b> , 19 <b>80</b> , to <b>March 31</b> , 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 31</b> , 19 <b>80</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Edward Suarez</b>		22c. DATE SIGNED <b>March 31, 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edward Suarez, M.D.</b>		22e. ADDRESS <b>9000 Franklin Square Dr., Balto., Md. 21237</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 2, 1980</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 1 1980</b>	
		25b. REGISTRAR'S SIGNATURE <b>Henry McBrady</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7. REG. NO.		8 0 0 6 2 4 8							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2. DATE OF DEATH MONTH DAY YEAR			2b. HOUR a		
John Cleveland Tabor						3 13 80			4:30 M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		white		August 18, 1931		48 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MD.					
Maryland		USA				Baltimore County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rossville 21237		Franklin Square Hospital				Plant Manager		Tie Mfg. Co.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
Maryland			Baltimore		Essex				908 Lance Ave. 21221		
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
George Cleveland Tabor				Elizabeth - Brown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT (sister) ADDRESS							
yes		1952-1953		213-28-2635		Barbara Miraglivoll 237 Burns Crossing Rd. Severn Maryland 21144					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary arrest											
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of lung											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
				2/24/ 80 to 3/13/ 80							
22a. I certify that (I) (this hospital) attended the deceased from 3/13/ 80 to 3/13/ 80, that (I) (we) last saw the deceased alive on 3/13/ 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edward Suarez				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3/13/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward Suarez, M.D.				22e. ADDRESS 9000 Franklin Square Drive 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		3-15-80		Holly Hill Memorial		Baltimore County, Maryland					
24. FUNERAL DIRECTOR Pruddzinski Funeral Home PA 1407 Old Eastern Ave.				25a. DATE REC'D. BY REGISTRAR MAR 13 1980		25b. REGISTRAR'S SIGNATURE					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 006249				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Donald George Taggart				2a. DATE OF DEATH MONTH DAY YEAR March 7, 1980				2b. HOUR 3:00 AM
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 28, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD		
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2503 Glencoe Rd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager- RadioShack		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland				13b. COUNTY Baltimore	13c. CITY OR TOWN Parkville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Charles A. Taggart				15. MOTHER'S MAIDEN NAME FIRST MIDDLE Florence E. Dudley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 219-03-1793		17. INFORMANT ADDRESS Mrs. Margaret M. Taggart		Same as 13e		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION - 410- DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from Nov 19 12 to March 6 19 80, that (1) (we) saw the deceased alive on 3/6 19 80, and that it (was) (was not) an opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Leonard J. Ruck Inc.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/11/80.		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leonard J. Ruck Inc.				22e. ADDRESS 7600 Osceola Rd 21204				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 10, 1980		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc.				ADDRESS Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR MAR 11 1980		25b. REGISTRAR'S SIGNATURE R. J. Ruck

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 0 0 6 2 5 0				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WHITNEY C. TAYLOR					2a. DATE OF DEATH MONTH DAY YEAR MARCH 21, 1980			2b. HOUR 3:15 a.m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 27, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Maintenance	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST ? Taylor					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret (Unk)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		17. INFORMANT Mrs Abigail Taylor		ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 2859 IMMEDIATE CAUSE (a). <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b). <u>Severe cardiovascular atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c). <u>Severe anemia, Gangrene of left foot</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION 3/12/80, 2/19/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene of left lower leg and left toes				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>February 8</u> , 19 <u>80</u> , to <u>March 21</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>March 21</u> , 19 <u>80</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.									
22b. SIGNATURE ming hu M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED march/21/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ming Hu				22e. ADDRESS 7620 York Road, Towson, MD 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/24/80		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 24 1980		25b. REGISTRAR'S SIGNATURE Petryal Brady			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 0 6 2 5 1

1. DECEASED NAME (TYPE OR PRINT) <b>LIELA TEITELL</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3 29 80</b>		2b. HOUR <b>9:55</b> M
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 19 19</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTIMORE MEDICAL CENTER</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>BALTO.</b>	13d. STREET ADDRESS <b>6111 YORK RD. #21212</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>PHILIP SACHS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY BRODIE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-14-7776</b>	17. INFORMANT <b>MR. EMIL TEITELL</b> <b>6111 YORK RD. BALTO., MD 21212</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Feb-Ching Wang</i>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>3/29/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. WANG</b>	22e. ADDRESS <b>6701 NORTH CHARLES STREET, 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>MAR. 31, 1980</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OHEB SHALOM</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>REISTERSTOWN BALTO MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 2 1980</b>		
		25b. REGISTRAR'S SIGNATURE <i>Anthony M. Brady</i>		

TELETYPE

FIELD

WALTHAM COUNTY

T. H. SMITH, CHIEF OF POLICE, BOSTON

CONSTITUTIONAL PARTY

1930

1930

100 NORTH CHURCH STREET, BOSTON

WALSH

DR.

1930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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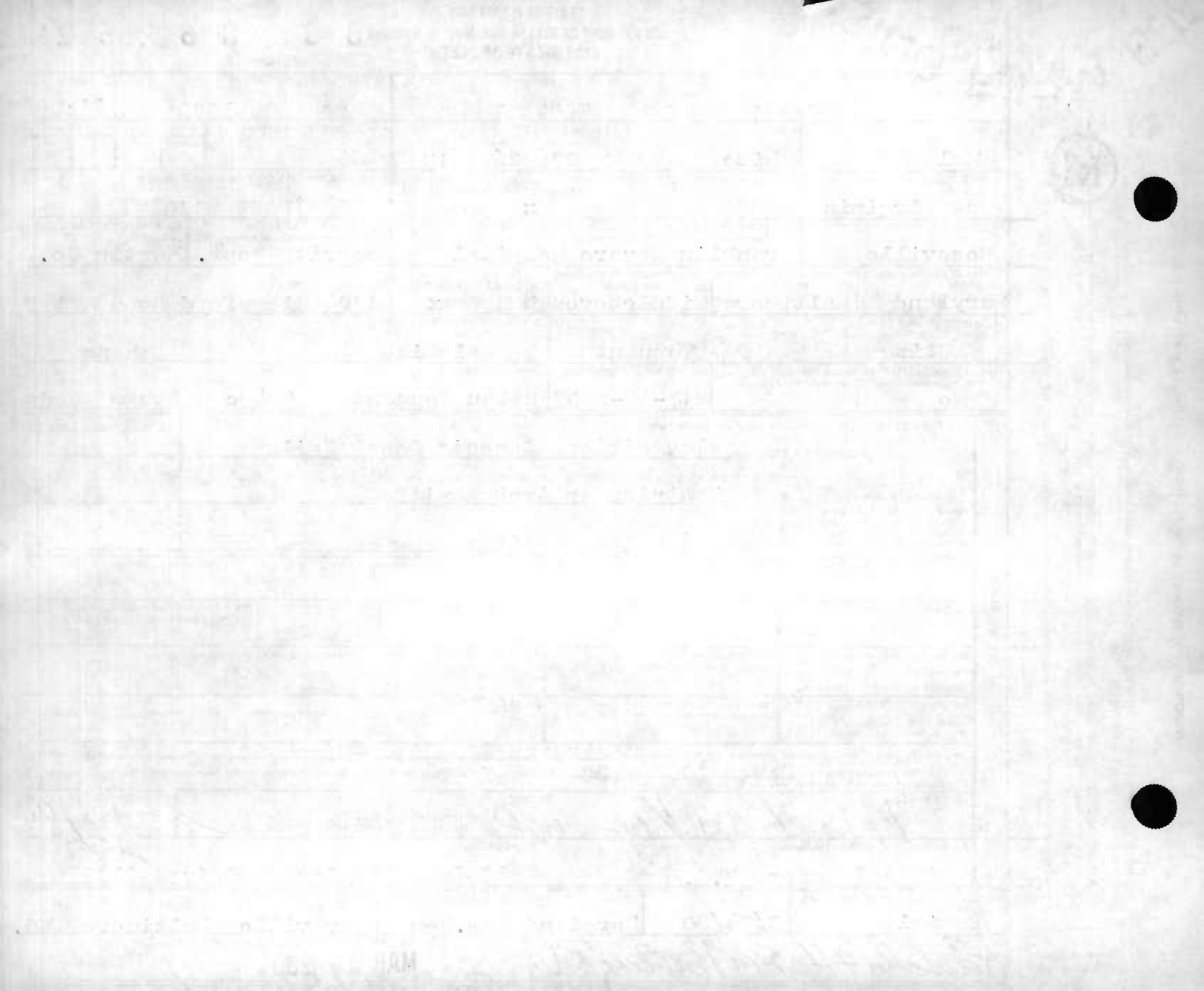
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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 0 6 2 5 2  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Cecil C TENNANT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 20, 1980</b>			2b. HOUR <b>11:00AM</b>									
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>07 26 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS		# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>									
10. CITY OR TOWN OF DEATH <b>Rossville</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Security Dept.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Martin Co.</b>						
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Middleborough</b>			13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			13e. STREET ADDRESS <b>1104 Glemsford Road Apt F</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Otis Tennant</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Delphia Shane</b>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>217-12-0637</b>			17. INFORMANT <b>Helen Tennant</b>			ADDRESS <b>9040c Waltham Woods</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malnutrition, Chronic Renal Failure</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ventricular Arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <b>February 28, 1980</b>		CITY OR TOWN <b>March 20, 1980</b>		COUNTY <b>that X (we) lost</b>		STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>February 28, 1980</b> to <b>March 20, 1980</b> , that X (we) lost saw the deceased alive on <b>March 20, 1980</b> , and that in X (our) opinion death occurred on the date and hour and from the causes stated above, Y (we) (did) (did not) view the body after death.															
27b. SIGNATURE <b>Michael Koger</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED <b>3/20/80</b>					
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael Koger, M.D.</b>						27e. ADDRESS <b>9000 Franklin Square Drive 21237</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/24/80</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Cem</b>			23d. LOCATION CITY OR TOWN <b>Parkville</b>			COUNTY <b>Baltimore</b>		STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>James H. 749 Bepay Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1980</b>			25b. REGISTRAR'S SIGNATURE <b>Jeffrey McCreedy</b>						





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. FOR STATE REGISTRAR			REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>LUCY</b>			FIRST <b>TERRASI</b>			LAST			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 29, 1980</b>		2b. HOUR <b>10:00</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>DEC. 16, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b>		7. YRS. MONTHS DAYS <b>87</b>		8. IF UNDER 1 YEAR HOURS MIN <b>87</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ITALY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.						
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTIMORE MEDICAL CTR.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>TOWSON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1583 DOXBURY RD.</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH DiBENEDETTO</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANTONIA SCARDINO</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>088-01-2300</b>		17. INFORMANT <b>MRS. VIVIAN KAUFMANN</b>				ADDRESS <b>SAME</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> <b>5198</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RESPIRATORY INFECTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 DAYS</b> <b>6 DAYS</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>DEHYDRATION</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 28, 1980</b> to <b>MARCH 29, 1980</b> , that (I) (we) lost saw the deceased alive on <b>MARCH 29, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Lawrence Vidaver</i>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3-29-80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAWRENCE VIDAVER</b>				22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL TRANSIT</b>		23b. DATE <b>APRIL 2, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LONG ISLAND CITY, NEW YORK</b>						
24. FUNERAL DIRECTOR NAME <b>MITCHELL-WIEDEFELD HOME, INC.</b>		ADDRESS <b>6500 YORK RD. BALTO., MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 1 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Richard M. Brady</i>						

MARCH 22, 1980 10:00

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DEC. 16, 1982

WATIN

RE LA

SALT HOLE COUNTY

USA

AT LA

GREATER BALTICORE MEDICAL CTR. BALTIMORE

1233 DUBLIN RD. BALTIMORE, MARYLAND

JOSEPH D. BARNETT

01-01-1980 - 01-01-1980

RESPIRATORY FAILURE

RESPIRATORY INFECTION

DEHYDRATION

MARCH 22, 1980

LONG ISLAND CITY, NEW YORK

6500 YORK RD. BAYVIEW, MD. 21214

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
1. FOR STATE REGISTRAR		REG. NO.																	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		a	
Brook						TETER		3		27		80		10:05		M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS		MONTHS		DAYS		HOURS		MIN.	
Male		Caucasian		Oct. 6, 1911		68		YRS.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH													
West Virginia		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore County												MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		Franklin Square Hospital		Kerry-Springfield		Fire													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
West Virginia		Pendleton		Onego		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.D.											
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
FLOYD		TETER		PALLIE		HARPER													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS													
Yes		WW II		236-20-9051		Priscilla Teter/wife		same as 13											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Pneumonia																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
Chronic lymphocytic leukemia; Atherosclerotic coronary artery disease																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR																	
(IF EITHER, NOTIFY MEDICAL EXAMINER)		P.M. 19																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION															
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE									
AT WORK																			
22a. I certify that <del>the</del> (this hospital) attended the deceased from 3-14-1980 to 3-27-1980, that (he) (we) last saw the deceased alive on 3-27-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE		DEGREE		22c. DATE SIGNED															
AIMAN N. DAGHESTANI		M.D.		3/27/80															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
AIMAN N. DAGHESTANI, M.D.		Franklin Square Hospital																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE							
Burial		1980 Mar. 31,		North Fork		Pendleton Co., W. Va.													
24 FUNERAL DIRECTOR		25a. BY RECORD		25b. REGISTRAR'S SIGNATURE															
NAME		ADDRESS																	
Capitol Funeral Service		Fairfax, Va.																	

WASHINGTON, D. C.

OFFICE OF THE SECRETARY

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

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WATER RESOURCES DIVISION

BP  
DHMH - 17  
(VR A15 ME (5))  
15M/7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles Henry Thomas			20. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 5 17 1980			2b. HOUR 6:15 AM		
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR May 13, 1920	6. AGE (IN YEARS) LAST BIRTHDAY 59 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 17 1980		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD		
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2613 Westchester Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) machinist		12b. KIND OF BUSINESS OR INDUSTRY D.C.A.
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 2613 Westchester Ave. (21043)		
14. FATHER'S NAME FIRST MIDDLE LAST Richard W. Thomas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Wright					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT 2613 Westchester Ave. Edith Thomas Ellicott City, Maryland 21043				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few days								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE E.P. Williams			TITLE (SPECIFY) M.D.			DATE SIGNED 3/17/80		
EXAMINER'S NAME (TYPE OR PRINT) E.P. Williams			ADDRESS 5550 BALTO NAT'L Pike					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 3/20/80		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City, Howard, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS SLACK Funeral Home, Ellicott City, Maryland 21043					25a. DATE REC'D. BY REGISTRAR MAR 20 1980		25b. REGISTRAR'S SIGNATURE Mickey McCreary	

<p>1</p>	<p>2</p>	<p>3</p>	<p>4</p>
<p>5</p>	<p>6</p>	<p>7</p>	<p>8</p>
<p>9</p>	<p>10</p>	<p>11</p>	<p>12</p>
<p>13</p>	<p>14</p>	<p>15</p>	<p>16</p>
<p>17</p>	<p>18</p>	<p>19</p>	<p>20</p>
<p>21</p>	<p>22</p>	<p>23</p>	<p>24</p>
<p>25</p>	<p>26</p>	<p>27</p>	<p>28</p>
<p>29</p>	<p>30</p>	<p>31</p>	<p>32</p>
<p>33</p>	<p>34</p>	<p>35</p>	<p>36</p>
<p>37</p>	<p>38</p>	<p>39</p>	<p>40</p>





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 06256

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE PRONOUNCED DEAD		2d. HOUR	
LILLIE E. THOMPSON		3. 7 19 80		1 57 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
FEMALE	WHITE	08 26 08	71 YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED	
MARYLAND		U.S.A.		NEVER MARRIED	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Carmichael		2404 Bradford Rd 21234		CLERK	
13a. STATE		13b. COUNTY		13c. STREET ADDRESS	
MARYLAND		DORCHESTER		RT. 1 BOX 185 D	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		12b. KIND OF BUSINESS OR INDUSTRY	
LUMAN		PARKHURST		W.J. DICKY & SON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO		220-07-8104		ADDRESS E. New Market, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20. AUTOPSY?	
PART I DEATH WAS CAUSED BY:		19a. CONDITION FOR WHICH OPERATION WAS PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease					
4292					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
Gout. Arthritis					
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
P.M.		19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
J. C. Hyle		D. Hyle		3-7-80	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
J. C. Hyle		7527 Belair Rd Baltimore 21236			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		03-10-80		LOUDON PARK	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		MAR 11 1980		J. Hyle	
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.					

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FOR  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

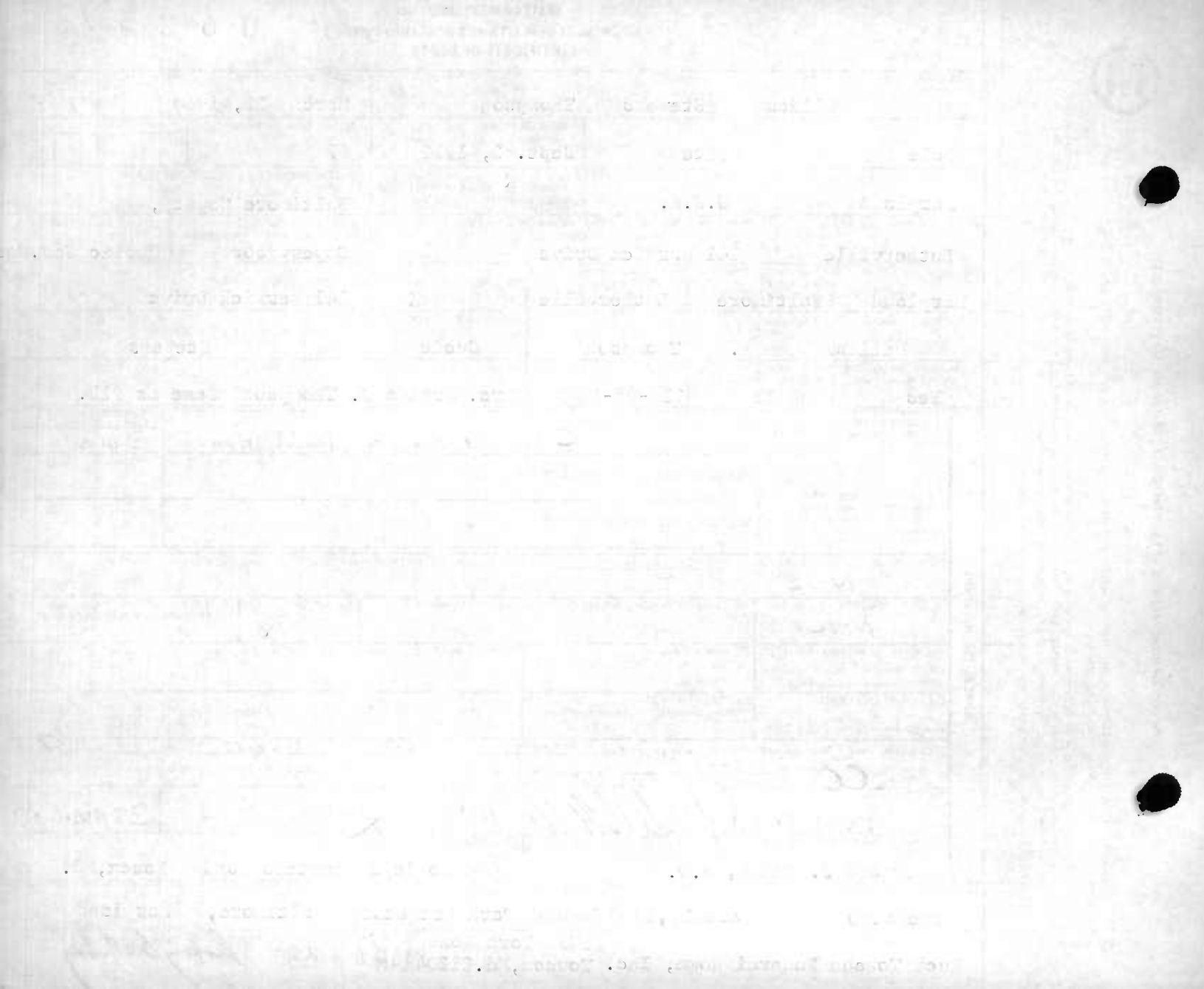
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1. DECEASED NAME (TYPE OR PRINT) <b>William Stevens Thompson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 26, 1980</b>		2b. HOUR <b>7<sup>15</sup> P M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 2, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS. MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Lutherville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>141 Warwick Drive</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Public Ser.Co.</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Lutherville</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William L. Thompson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susie Stevens</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 218-05-2083</b>		17. INFORMANT ADDRESS <b>Mrs. Frieda S. Thompson Same as #13.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1919</b> IMMEDIATE CAUSE (a) <b>GLIOBLASTOMA Multiphase</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>								
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <b>MARCH 1980</b> , to <b>3/26/80</b> , 19____, that (1) (we) lost saw the doctor on <b>3-26-80</b> , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death.)								
22b. SIGNATURE <b>Bernard J. Yukna</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>27 MAR 80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Bernard J. Yukna, M.D.</b>		22e. ADDRESS <b>404 Bowleys Quarters Road Essex, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>March 27, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>		ADDRESS <b>1050 York Road Towson, Md. 21204</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 28 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Rick McCreedy</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

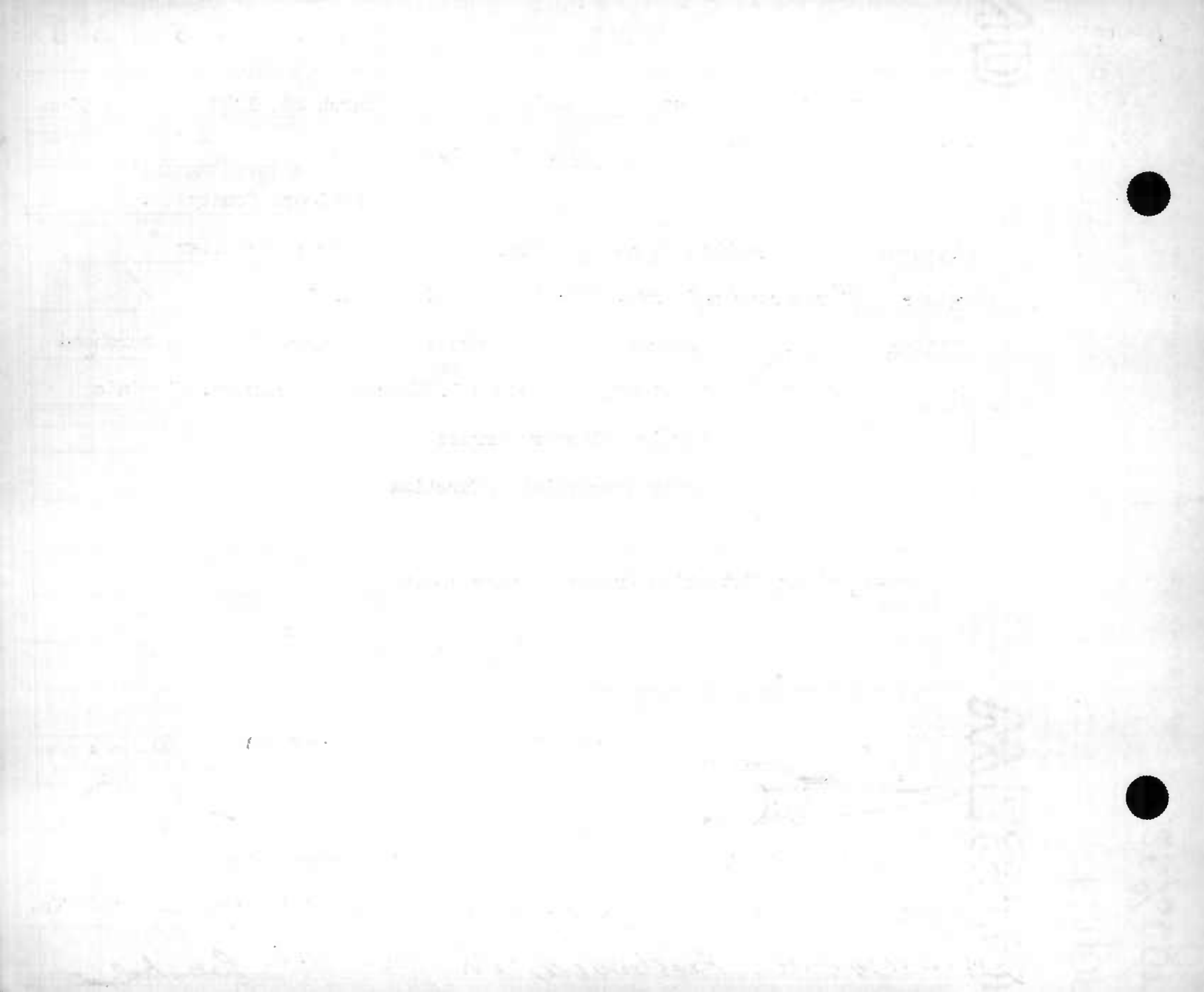


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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 0 6 2 5 8					
1. FOR STATE REGISTRAR					REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arthur James THORNE					2a. DATE OF DEATH MONTH DAY YEAR March 28, 1980					2b. HOUR 4:55 a.m.					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 1 1889			6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Carpenter			12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia					13b. COUNTY Northumberland			13c. CITY OR TOWN Reedville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 1	
14. FATHER'S NAME FIRST MIDDLE LAST William E. Thorne					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Margaret Mothershead										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. 228-10-1246			17. INFORMANT ADDRESS Arthur L. Thorne Montross, Virginia							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Acute Urinary Retention-Prostate Enlargement															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (this hospital) attended the deceased from March 7, 1980, to March 28, 1980, that (we) last saw the deceased alive on March 28, 1980, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) view the body after death.															
22b. SIGNATURE [Signature] DEGREE										22c. DATE SIGNED 3-28-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alexis Abril M.D.										22e. ADDRESS 9000 Franklin Square Drive 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/30/1980		23c. NAME OF CEMETERY OR CREMATORY Roseland Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Reedville Northumberland Va.							
24. FUNERAL DIRECTOR NAME Jones-Asch J. H.										24b. ADDRESS Heathsville Va		25a. DATE REC'D. BY REGISTRAR APR 3 1980		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 06259	
1. FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT) <b>Olive CICELY Tilden</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3/29/80</b>				2b. HOUR <b>2:55 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 22, 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>British W. Indies</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maryland C. Towson 509 E. Joppa Rd. Balt. 21204</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>				12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>TOWSON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>44 ACORN CIRCLE 21204</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDWARD FRANCIS PHILLIPS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ALICE ELIZABETH HARE</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214.60.1754</b>		17. INFORMANT ADDRESS <b>PHILIP V. TILDEN, JR. 1-1634 MANOR RD., GLEN ARM, MD. 21057</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <b>Cardiac Arrest</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis Cardiac Insufficiency 10yrs</b>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7:30 P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>2 Nov 73</b> to <b>2/29 80</b> , that (I) (we) lost saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Walter T. Kees</b> DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>2/29/80</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALTER T. KEES</b>		22e. ADDRESS <b>Monkton Md 21111</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>3/31/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>WALTER BROOKS BRADLEY, INC., BALTIMORE, MD.</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 1 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Walter Brooks Bradley</b>			



WALTON  
TO THE HONORABLE  
THE CHIEF OF BUREAU

Office of the Chief of Bureau  
Washington, D.C.

Dear Sir:  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the

proposed amendment to the Constitution of the District of Columbia, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Your obedient servant,  
J. M. Smith

Very truly yours,  
J. M. Smith

Enclosed for you are two copies of the proposed amendment to the Constitution of the District of Columbia, as submitted to the Board of Commissioners.

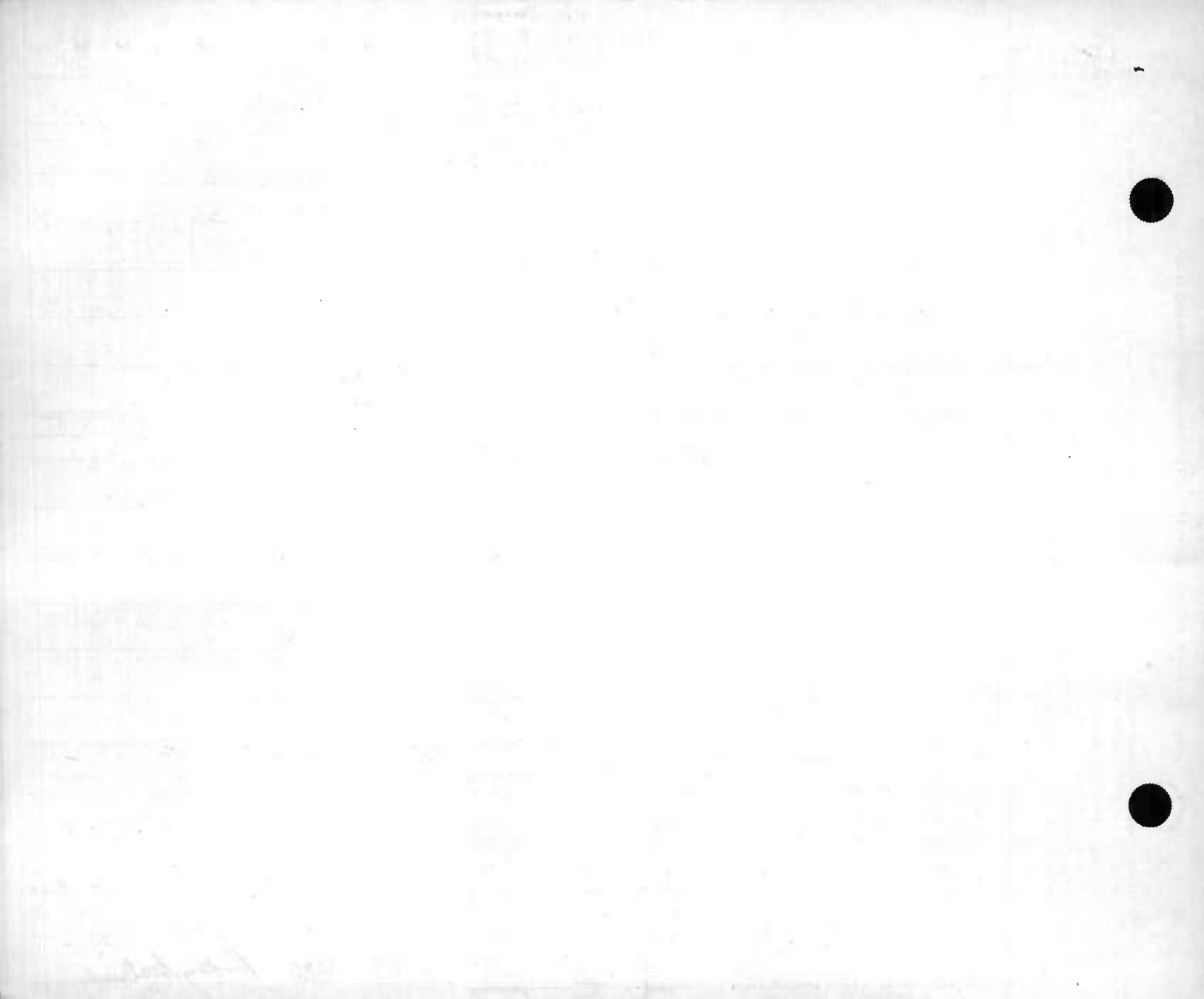
I am, Sir, very respectfully,  
Your obedient servant,  
J. M. Smith

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
BESSIE TOLOCHKO						March 27, 1980			9 P M
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR IF UNDER 24 HRS	
FEMALE		WHITE		AUG. 25, 1897		82 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
PENNSYLVANIA		USA				BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON		DULANEY-TOWSON NURSING HOME				HOUSEWIFE		AT HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. CITY OR TOWN		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS		
13a. STATE			BALTO.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3501 PHILLIPS DR. #21208		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
JACOB SHAPIRA			LENA BAWORSKY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
NO					BURTON L. HINSON FURNAL HOME 2704 MURRAY AVE., PITTSBURGH, PA 15247				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>5 yrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this person) attended the deceased from <u>4/1</u> , 19 <u>78</u> , to <u>3/27</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3/24</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE			DEGREE			22c. DATE SIGNED			
<u>Morton M. Mower</u>						3/27/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
MORTON M. MOWER			200 W. COLDSRING LA. BALTO. MD. 21218						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL/REMOVAL			3/28/80		BETH SHALOM		SHALER TOWNSHIP BALTIMORE		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.						25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
6010 REISTERSTOWN RD. BALTO. MD 21215						APR 2 1980		<u>Robert M. Brady</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 1/75  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		JOHN DAVID TOOMEY					MARCH 5, 1980				3:10P M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		10 14 1912		67		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA		U.S.A.				BALTIMORE COUNTY				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
FORT HOWARD		Y.A.M.C., FORT HOWARD, MARYLAND		Pres. Rosedale Fed.S & L Assn/							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5811 Loch RAVEN BLVD.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
John D. Toomey		Nellie Haley									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
YES		WWII		216 14 3443		CLINICAL RECORD, VAMC, FORT HOWARD, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE RESPIRATORY FAILURE</u> 496- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		COR PULMONALE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 21</u> , 19 <u>80</u> , to <u>MARCH 5</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>MARCH 5</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>C.V.J. Vergheese</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/6/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
C.V.J. VERGHESE, M.D.		V.A.M.C., FORT HOWARD, MARYLAND 21052									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		3/8/80		Loudon Park Cem.		Balto. City					
24. FUNERAL DIRECTOR (NAME)		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wiedefeld Home-6500 York Rd. 21212				MAR 12 1980		<i>John A. Kennedy</i>					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) AKA FIRST MIDDLE LAST NETTIE M. P. TRASHER						2a. DATE OF DEATH MONTH DAY YEAR 31 March 1980		2b. HOUR 1:30 P.M.			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 10 21 05		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10 CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUMMIT NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESLADY		12b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE			
13a. STATE MARYLAND				13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1049 DE SOTO ROAD, 21223			
14 FATHER'S NAME FIRST MIDDLE LAST LOGAN				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADA ANDERSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO 215-10-3071		17 INFORMANT ADDRESS VIRGINIA GALLOWAY 1049 DE SOTO ROAD					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Progressive occlusive Vascular Disease</i> <i>1570</i> DUE TO OR AS A CONSEQUENCE OF CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last: } <i>with multiple areas of gangrene.</i> <i>Sarcinoma of head of pancreas.</i> DUE TO OR AS A CONSEQUENCE OF } <i>Subcapital fracture left hip.</i> <i>Pulmonary emphysema - hypotension</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Generalized inanition.</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>March 31</i> 19 <i>80</i> to <i>31 March</i> 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>31 Mar</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Joseph E. Muse Jr. M.D.</i>				22c. DATE SIGNED 4/2/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH E. MUSE, JR., M.D.				22e. ADDRESS 901 Pine Hills Ave. Balto. Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 04-03-80		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND					
24 FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.				24b. ADDRESS 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR APR 02 1980		25b. REGISTRAR'S SIGNATURE <i>John J. Brady</i>			

UNITED STATES  
DEPARTMENT OF AGRICULTURE

REPORT

OF THE

COMMISSIONER

OF THE

LAND OFFICE

AND

REVENUE

OF THE

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OFFICE

AND

REVENUE

OF THE

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UNITED STATES

DEPARTMENT OF AGRICULTURE

REPORT

OF THE

COMMISSIONER

OF THE LAND OFFICE AND REVENUE

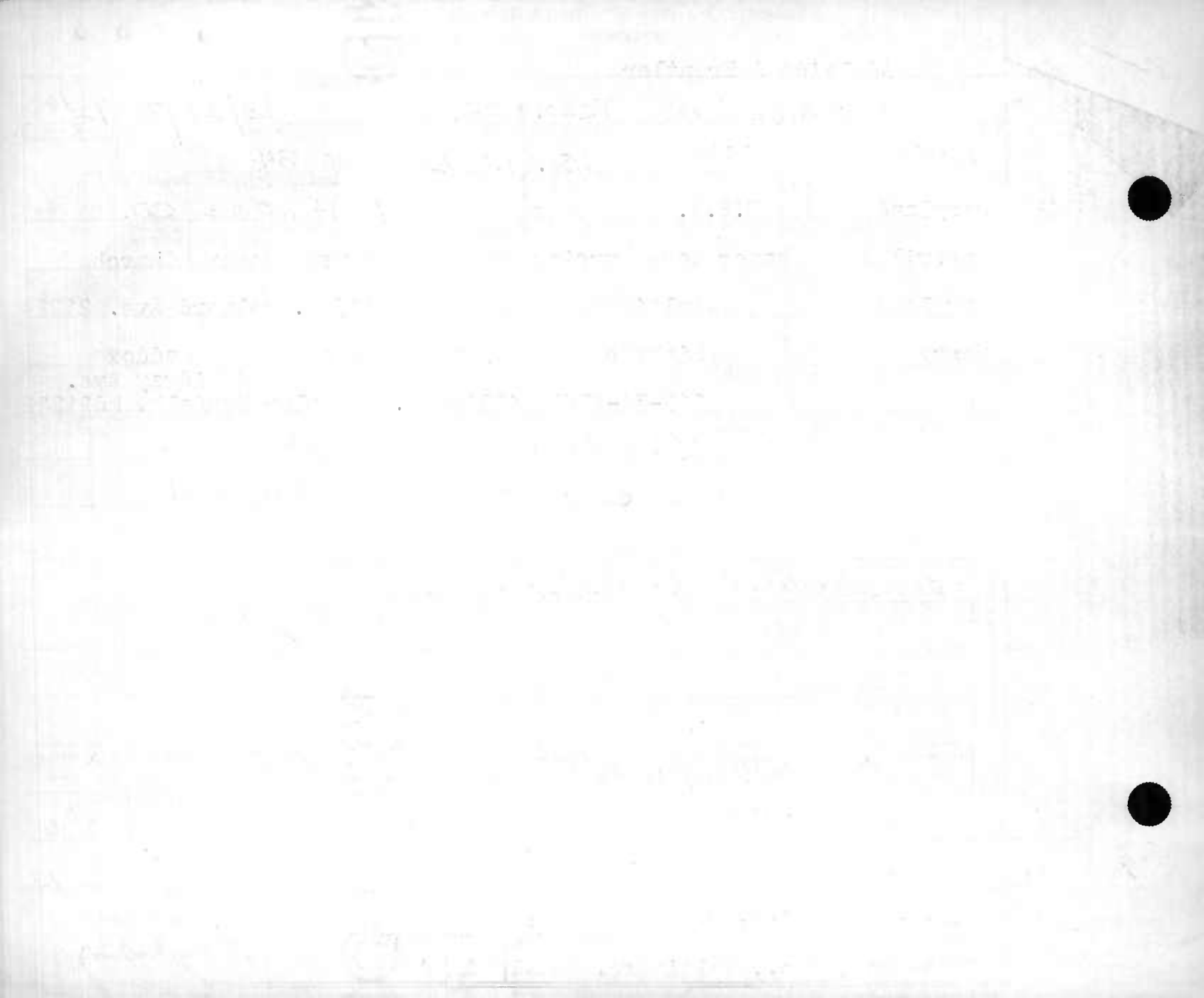


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR <b>Adelaide A. Trentler</b>					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>ADELAIDE A. TRENTLER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>3/24/80</b>			2b. HOUR <b>12:30</b> M	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Aug. 18, 1893</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CO.</b> MD.			
10 CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House Keeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Church</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>115 N. Belnord Ave. 21224</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Einhaus</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Mae Maddox</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-34-5763</b>		17 INFORMANT ADDRESS <b>4 Midway Ave. William H. Trentler Dundalk, Md 21222</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Haemorrhage</b> <b>431-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Cerebro-vascular atherosclerosis</b> (c) <b>Atherosclerotic Cardiovascular disease</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Atherosclerotic Cardiovascular disease</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11:13/78</b> 19 <b>3/24/</b> 19 <b>80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11:13/78</b> 19 <b>3/24/</b> 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12:00pm 3/24/1980</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>M. J. Tun</b>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/25/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KHIN-M. TUN</b>					22e. ADDRESS <b>2110 Pot Spring Road Balto Md 21093</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/28/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc., Baltimore, Maryland</b>					RECORDED BY REGISTRAR <b>MAR 28 1980</b>		25 REGISTRAR'S SIGNATURE <b>Philip McCready</b>		







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 8006265				
1. DECEASED NAME (TYPE OR PRINT) <b>Catherine B. Truelove</b>					2a. DATE OF DEATH MONTH <b>3</b> DAY <b>7</b> YEAR <b>1980</b> 2b. HOUR <b>12:55am</b>				
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>28</b> YEAR <b>1886</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Little Sisters of the Poor</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b></b>		13c. CITY OR TOWN <b>Baltimore</b>		13e. STREET ADDRESS <b>3640 Roland Avenue, 21211</b>			
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>P.</b> LAST <b>Gahan</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Margaret</b> MIDDLE <b></b> LAST <b>Casserly</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>218-52-0265</b>		17. INFORMANT ADDRESS <b>Sr. Pauline 601 Maiden Choice Lane-Balto.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden death - massive</b> <b>5789</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>myocardial infarction, A.S.C.D.</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>decreased sensibility. Anemia due to bleeding.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 1956</b> , to <b>3.7. 1980</b> , that (I) (we) last saw the deceased alive on <b>3.6. 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Stanley Ankudias</b> DEGREE <b>MD</b>					22c. DATE SIGNED <b>3.7. 80</b>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STANLEY ANKUDIAS</b>	
22e. ADDRESS <b>1101 Maiden Choice La, Baltimore</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>03-10-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION CITY OR TOWN <b>Baltimore City</b> COUNTY <b>Maryland</b> STATE <b></b>		
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b> ADDRESS <b>4107 Wilkens Ave.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 11 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

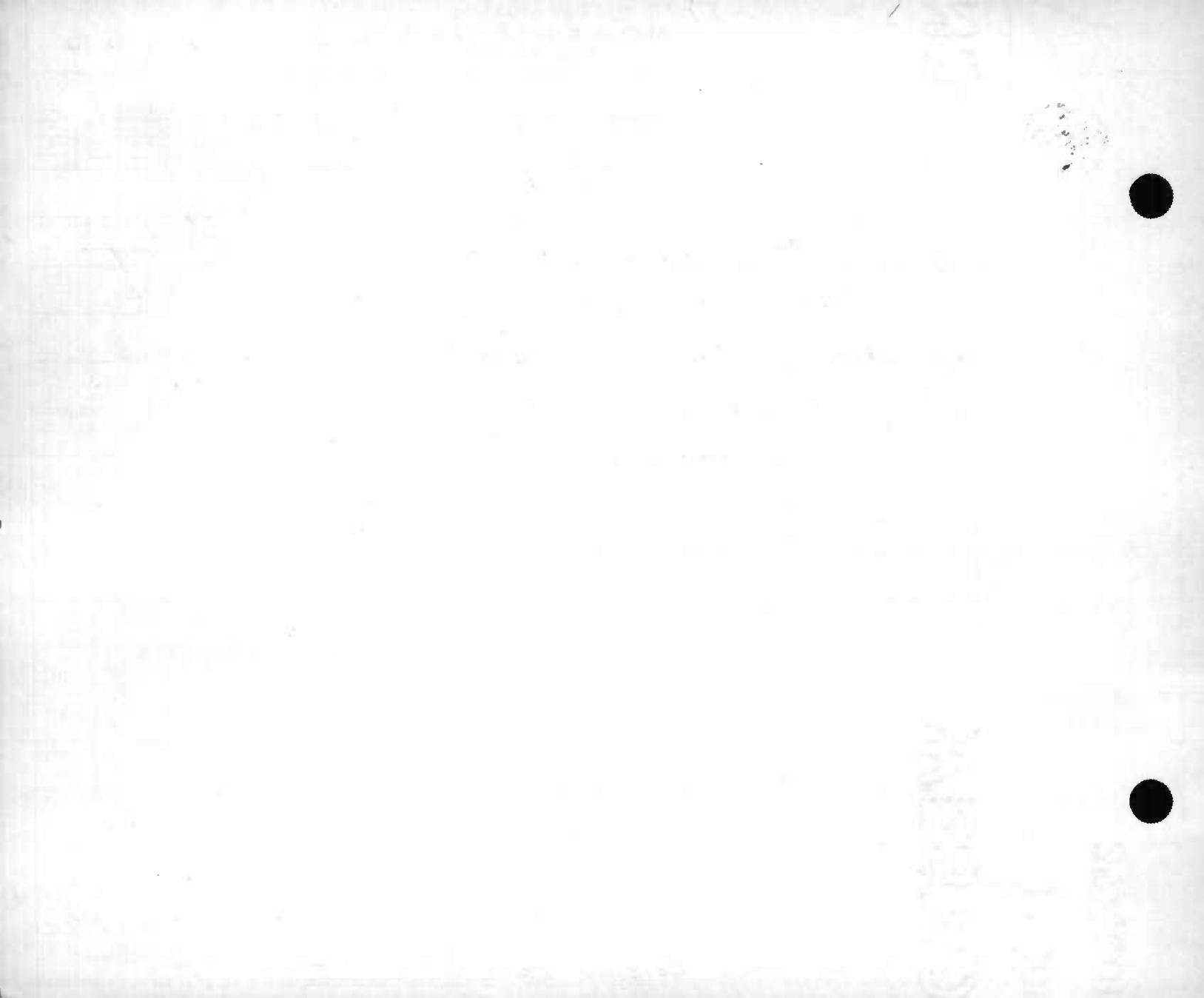
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR			REG. NO. 8 0 0 6 2 6 6						
1. DECEASED NAME (TYPE OR PRINT)			FIRST Emma	MIDDLE A.	LAST Uhl	2a. DATE OF DEATH MONTH DAY YEAR 3-15-80		2b. HOUR 9:30 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8-6-16		6. AGE (IN YEARS LAST BIRTHDAY) 63		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD			
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shawari-La Nursing Ctr.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 304 Smiths Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Christopher Ruark			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Simmons			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. NO			17. INFORMANT Shawari-La			17. ADDRESS 333 Harlem Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>bronchopneumonia carcinoma of lung</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles Wu, MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/15/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. WU						22e. ADDRESS 325 Hospital Drive, Suite 105, Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-18-80		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. MD		
24. FUNERAL DIRECTOR NAME Robert S. Barranco - Severna Park						25a. DATE REC'D. BY REGISTRAR MAR 19 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

BP





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

03 31 80 3<sup>00</sup> A M

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
WILLIAM H. ULRICH					03	31	80		3 <sup>00</sup> A M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE	WHITE	10 18 1887		92 YRS		MONTHS		DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND	U.S.A.			COUNTY					
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
CATONSVILLE	SHANGRI-LA NURSING CENTER		BRICKLAYER		CONSTRUCTION				
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS	
MARYLAND		HOWARD		ELLCOTT CITY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2836 MONTCLAIR DRIVE, 21043	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					
HENRY		ULRICH		16b SOCIAL SECURITY NO. 215-09-7538					
		HENRIETTA		17 INFORMANT ADDRESS ELLCOTT CITY, MD. 2836 MONTCLAIR DRIVE					
		PETERSON							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
410- ASCVD		DUE TO, OR AS A CONSEQUENCE OF		ch					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)							
		DUE TO, OR AS A CONSEQUENCE OF							
		(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
SIP MI Not CHK									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a I certify that (my (this hospital) attended the deceased from 19 80, to 19 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED			
M R		MD				3/31/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS							
M. Lekeca		5400 Old Court Rd.							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		23e STATE	
BURIAL		04-03-80		LOUDON PARK		BALTIMORE CITY		MARYLAND	
24 FUNERAL DIRECTOR NAME		ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
HUBBARD FUNERAL HOME, INC.		4107 WILKENS AVE.		21229		APR 02 1980			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. If retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

OFFICE OF THE ASSISTANT ATTORNEY GENERAL

WASHINGTON, D. C.

UNITED STATES DEPARTMENT OF THE INTERIOR

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UNITED STATES DEPARTMENT OF THE INTERIOR



Item 1g541 3/14/80 gj

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Henry Boy Cornelius UTENREITHER III</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 1, 1980</b>			2b. HOUR <b>8:20P M</b>					
3. SEX <b>Male</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 1 80</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>48 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS <b>48 YRS.</b>		IF UNDER 24 HRS. HOURS MIN. <b>48 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>-</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>=</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2027 E. Belvedere Ave.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry C. Uttenreither</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bonnie S. Atwell</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-</b>		17. INFORMANT ADDRESS <b>2027 Mr. Henry Uttenreither E. Belvedere</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity</b> <b>7610</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Premature labor</b> (c) <b>Incompetent cervix</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <b>3-1 March 1, 1980</b> , to <b>3-1-March 1, 1980</b> , that (we) lost saw the deceased alive on <b>3-1-March 1, 1980</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did not) view the body after death.											
22b. SIGNATURE <b>Jim A. Buck</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>3-1-80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jim A. Buck</b>				22e. ADDRESS <b>9000 Franklin Square Dr., 21237</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-3-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>					
24. FUNERAL DIRECTOR NAME <b>John C. Miller Inc.</b>				ADDRESS <b>6415 Belair Rd.</b>				25. DATE REC'D. BY REGISTRAR <b>MAR 5 1980</b>			
				25b. REGISTRAR'S SIGNATURE <b>Anthony Melnyk</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Lydia</b>		FIRST MIDDLE LAST <b>Vagenos</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>March 24, 1980</b>		2b. HOUR <b>4:00 A</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 18 98</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greece</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Multi-Medical Conv. &amp; Nurs. Cen.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b>		13c. COUNTY <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6608 Graceland Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Anthony Pazanis</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sevastoula</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-74-0290</b>		17. INFORMANT ADDRESS <b>Evgenios Vagenos, 6608 Graceland Avenue Baltimore, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF <b>Colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>many</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>months.</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/15</b> , 19 <b>80</b> to <b>3/24</b> , 19 <b>80</b> , that (I) (we) saw the deceased alive on <b>3/15</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.							
22b. SIGNATURE <b>Hans J. Koetter</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3-25-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HANS J. KOETTER, M.D.</b>				22e. ADDRESS <b>7600 OSLER DRIVE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-26-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greek Orthodox Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Nicholas T. Matthews, 3021 Eastern Avenue Baltimore, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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11/11/11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 06270	
1. DECEASED NAME (TYPE OR PRINT) Marry Wilson VAN NESS			2a. DATE OF DEATH MONTH DAY YEAR MARCH 9, 1980			2b. HOUR 4:45P M					
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Mar. 26, 1889		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Joppa Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3811 Canterbury Road					
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Wilson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Ray							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 215 01 5046		17 INFORMANT Mrs. Rose Mary Marlow Balto., Md.							
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 436 - DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis - generalized DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Weeks 2 years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from June 24, 1977 to March 9, 1980, that (I) (we) lost saw the deceased alive on March 8, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. Grafton Hersperger M-10 -				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/10/1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. W. Grafton Hersperger, M.D.				22e. ADDRESS Medical Arts Bldg., Balto., Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/11/80		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Md.					
24 FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co.				24b. ADDRESS 4905 York Road Balto., Md. 21212		25a. DATE REC'D. BY REGISTRAR MAR 11 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DR. ELMON LOUIS VERNIER</b>			2a. DATE OF DEATH MONTH <b>03</b> DAY <b>22</b> YEAR <b>80</b>			2b. HOUR <b>11:30</b> <sup>A</sup> <sub>M</sub>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>1</b> DAY <b>27</b> YEAR <b>05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. COUNTY, MD.</b>					
10. CITY OR TOWN OF DEATH <b>TOWSON, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>G.B.M.C.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Health Director</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>Baltimore</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>2 Knoll Ridge Court</b>		
14. FATHER'S NAME FIRST <b>Alfred</b> MIDDLE <b>O.</b> LAST <b>Vernier</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Dora</b> MIDDLE <b>A.</b> LAST <b>Decker</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WW 11</b>		17. INFORMANT ADDRESS <b>Mrs. Bertha M. Vernier Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>1420 IMMEDIATE CAUSE (a) CARDIAC ARREST</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CA OF PAROTID WITH METASTASIS</b>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2-24</b> , 19 <b>80</b> , to <b>3-22</b> , 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>3-22</b> , 19 <b>80</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) not view the body after death.											
22b. SIGNATURE <i>Anthony M. Vetere</i> MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>3-22-80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. ANTHONY M. VETERE, M.D.</b>						22e. ADDRESS <b>6701 N. CHARLES ST. TOWSON, MD. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>3/25/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Road Balto., Md. 21212</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 24 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Robert M. ...</i>			

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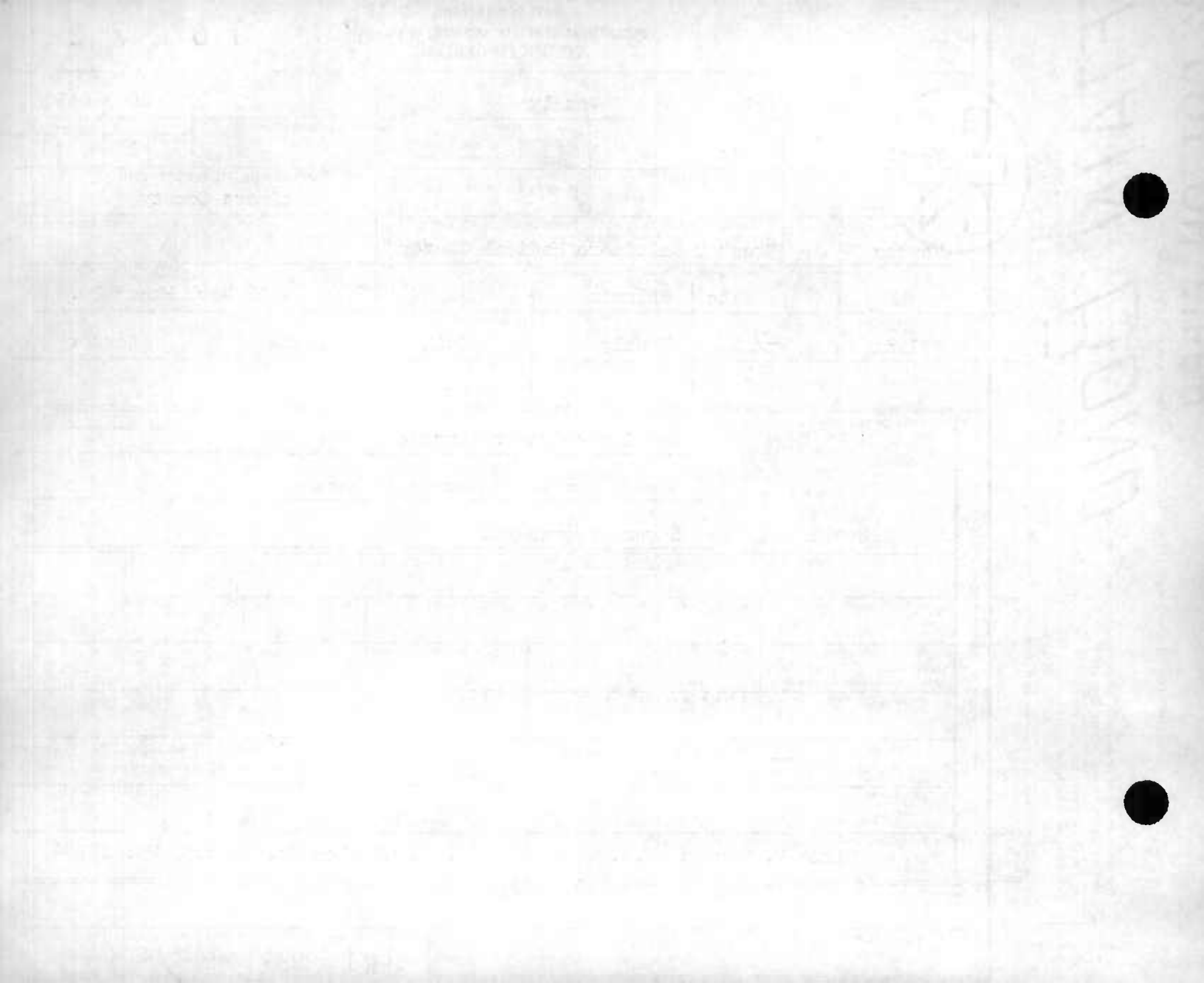
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 006272				
1. DECEASED NAME (TYPE OR PRINT) <b>Baby Girl Vesely</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>3 23 80</b>			2b. HOUR <b>4:10A<sub>M</sub></b>	
3. SEX <b>Female</b>		4. RACE <b>Cau</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 22 80</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>YRS. 1</b>		IF UNDER 1 YEAR MONTHS DAYS <b>1</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD</b>			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Baltimore Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Balto</b> 13c. CITY OR TOWN <b>Phoenix</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2912 York Manor Rd.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Frank Vesely</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gail Louise Carter</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>mother</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>Cardiorespiratory arrest</b> IMMEDIATE CAUSE (a) <b>769- Severe hyaline membrane disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Severe prematurity</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/22</b> , 19 <b>80</b> , to <b>3/23</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>3/23</b> , 19 <b>80</b> , and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Virma V. Torres</b> DEGREE <b>M.D.</b>					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Virma V. Torres, M.D.</b>					22e. ADDRESS <b>6701 N. Charles St. Towson, Md. 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR <b>APR 1 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE CERTIFICATE. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 06273

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
John Robert Waddell		2a. DATE OF DEATH		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH	
male		white		9-9-25	
6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
54 YRS.		MONTHS DAYS HOURS MIN.		2 1 19 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Md.		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Catonsville		Spring Grove Hospital		Driver	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.		Balto.		Balto.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
Charles E. Waddell		Rose Smith		212-20-0256	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17. INFORMANT		ADDRESS	
(IF YES, GIVE WAR OR DATES)		Mrs. Grace M. Waddell		-19 Hayley Rd. -21221	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease					
IMMEDIATE CAUSE (a) 4292					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Hormez R. Guard, M.D.		Assistant		2/1/80	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Hormez R. Guard, M.D.		111 Penn Street, Balto., MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2-4-80		Gardens of Faith Cem.	
24. FUNERAL DIRECTOR		ADDRESS		25. DATE REC'D. BY REGISTRAR	
John C. Miller Inc-6415 Belair Rd.-21206				FEB 03 1980	

25. DATE REC'D. BY REGISTRAR

25. REGISTRAR'S SIGNATURE





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 0 6 2 7 4			
FOR 1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Amelia L. Walkemeyer				2a. DATE OF DEATH MONTH DAY YEAR March 11, 1980		2b. HOUR 1:30 AM	
3 SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 5 25 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO Co. MD.	
10. CITY OR TOWN OF DEATH Towson Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mall Medical Center's Nursing		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY Baltimore		13c. CITY OR TOWN Owens	
14. FATHER'S NAME FIRST MIDDLE LAST John Lang				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST 1946 Cedar Rd. Russell E. Connelly Poplar Ridge			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-09-0656		17. INFORMANT ADDRESS 1946 Cedar Rd. Russell E. Connelly Poplar Ridge			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3-10</u> , 19 <u>80</u> , to <u>3-11</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>3-10</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John C. Hyle				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-11-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN C. Hyle				22e. ADDRESS 7527 Belair Rd Baltimore 1236 Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) entombment		23b. DATE 3/13/80		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Baltimore Md.	
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home 7401 Belair Rd.				25a. DATE REC'D. BY REGISTRAR MAR 17 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

Film G522 4/15/80 18c, 19c, 20c dad									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 80 06275									
1. DECEASED NAME (TYPE OR PRINT) <b>FREDERICK Joseph WALLACE</b>					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR
					3 2 80		12:00 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE		CAUCASIAN		Nov. 4, 1890		89		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.				Baltimore County MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Randallstown		Baltimore Co. Hospital		Carpenter		Bldg.			
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		
Md.					Carroll		Sykesville		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST					FIRST MIDDLE LAST				
Fred Wallace					Frances Muth				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					219 01 9685		Gloria Fleming Sykesville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <b>cardiac Arrhythmias</b>									
4413									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <b>Poss. Recent Myocardial Infarction</b>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <b>shock 2° Ruptured abdominal aortic aneurysm</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
3-2-80		GUARDED for ruptured abdominal aneurysm		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN COUNTY STATE			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK									
22a. I certify that (I) (this hospital) attended the deceased from <b>3-2-1980</b> , to <b>3-2-1980</b> , that (I) (we) last saw the deceased alive on <b>3-2-1980</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		22c. DATE SIGNED		
<i>[Signature]</i>							3-2-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
DR. S. D. PATEL					BAL. County Gen. Hosp. Old Court Rd. BAL. MD 21133				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Burial		3-5-80		Lorraine Park Cemetery		Baltimore		Md.	
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
NAME ADDRESS					MAR 6 1980		<i>[Signature]</i>		
Harry W. Haight Sykesville, Md.									



1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Elvin Sidney		WARD		March 24, 1980		5:15 <sup>a</sup> M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male	White	January 25 1923		57		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia	USA			Baltimore County MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rossville	Franklin Square Hospital			Steel Worker		Steel	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
Md		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21205 4802 E. Hoffman Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
Ira Ward		Ethel Redden					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes		WW II		Mrs Carolyn Ward 4802 E. Hoffman St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Terminal Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Squamous Cell Carcinoma of Anus</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>March 12</u> , 19 <u>80</u> , to <u>March 24</u> , 19 <u>80</u> , that (we) lost saw the deceased alive on <u>March 24</u> , 19 <u>80</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) view the body after death.		22b. SIGNATURE <u>Daniel Ronchetta</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3/24/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Daniel Ronchetta M.D.		9000 Franklin Square Drive 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		3/28/80		Restwood		Hinton Summers W. Virginia	
24. FUNERAL DIRECTOR Duda Ruck Inc. 7922 Wise Ave. Dundalk Md				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				MAR 27 1980		<u>Richard McCreedy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 006277							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAY G. WATKINS						2a. DATE OF DEATH MONTH DAY YEAR March 2, 1980		2b. HOUR 4:45AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 02 14 1896		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. STATE MARYLAND						13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN SCHWINGER						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELENA HEERGUT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-74-1110		17. INFORMANT ADDRESS RITA D. LARSEN 6107 DEERBROOK ROAD, 21228					
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> 5990 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>urinary tract infection</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Ischemic heart disease - Cerebrovascular accident</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 17, 1980</u> to <u>March 2, 1980</u> , that (I) (we) last saw the deceased alive on <u>March 2, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE G. Hassen Pourmetabed, M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-2-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GHASSEN POURMETABED				22e. ADDRESS Balto. County General Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 03-04-80		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.				25a. DATE REC'D. BY REGISTRAR 21229 MAR 4 1980		25b. REGISTRAR'S SIGNATURE Rita D. Larsen			



*[Handwritten signature]*

1960

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH	
		SUSAN OWENS WATSON			MARCH 9, 1980	
3 SEX		4 RACE		5 DATE OF BIRTH		2b HOUR
Female		White		Aug. 12, 1889		4:15 a
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		6 AGE (IN YEARS LAST BIRTHDAY)		2c MONTH DAY YEAR
Maryland		USA		90 YRS		4:15 a
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH
Towson		College Manor Nursing Home				Baltimore County MD
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		13a STREET ADDRESS		
Homemaker		Own Home		Wyman Park Apartments		
13a STATE		13b COUNTY		13c INSIDE CITY LIMITS?		
Maryland		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.
Cyrus W. Owens		Eliza P. Brashears		No		213 48 8049
17 INFORMANT		18 ADDRESS		19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED
Mrs. Bainbridge Eager		Wash., D.C.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic Cardiovascular Disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a DATE OF OPERATION		21b CONDITION FOR WHICH OPERATION WAS PERFORMED
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>Feb 6th</u> 19 <u>80</u> to <u>3-9-</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>2/6/</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE <u>Dr. Kevin Quinn</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>3/15/80</u>		
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE
Dr. Kevin Quinn, M.D.		1205 York Road Balto., Md.		Cremation		3/12/80
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE		24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR
Greenmount		Balto., Md.		Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212		MAR 11 1980
25b REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>						



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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					REG. NO. 8 0 0 6 2 7 9				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>LEONARD J. WEISS</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>3 2 80</u>				2b. HOUR <u>6:45AM</u>
3. SEX <u>MALE</u>		4. RACE <u>CAUCASIAN</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>MAY 7, 1910</u>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <u>69</u> YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>NEW YORK</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE COUNTY</u> MD.			
10. CITY OR TOWN OF DEATH <u>RANDALLSTOWN</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>BALTIMORE COUNTY GEN. HOSP.</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>MANAGEMENT</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>MOTEL</u>	
13a. US RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <u>MARYLAND</u>		13b. COUNTY <u>BALTIMORE</u>		13c. CITY OR TOWN <u>BAILEYS CROSS</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>6251 COLUMBIA PIKE #22041</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>JACQUES WEISS</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>CECEIL UNKNOWN</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>				16b. SOCIAL SECURITY NO. <u>137-09-3112</u>		17. INFORMANT <u>MR. STEPHEN WEISS</u> <u>4107 BALMORAL CIR. BALTO., MD 21207</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>cardiac Arrhythmias</u> <u>410-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recent Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Cardio-Vascular Disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-26</u> , 19 <u>80</u> , to <u>3-2</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3-2</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE				22c. DATE SIGNED <u>3-2-80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR. SUDHIR D. PATEL</u>				22e. ADDRESS <u>Bal. County Gen. Hosp. 21133 Old Court Road, Randallstown.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>				23b. DATE <u>MAR. 3, 1980</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LOU DON PARK</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTIMORE MARYLAND</u>	
24. FUNERAL DIRECTOR NAME <u>SOL LEVINSON &amp; BROS., INC.</u> <u>6010 REISTERSTOWN RD. BALTO., MD 21215</u>						25a. DATE REC'D. BY REGISTRAR <u>MAR 5 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP.





1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Evelyn May Wharran			2a. DATE OF DEATH MONTH DAY YEAR March 25, 1980			2b. HOUR A M 3:10	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR October 10, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Essex 21221		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 115 "C" Country Terrace Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Home							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Essex 21221		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Clarence - Hanson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose May Sweeney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Nelson Wharran, husband Same			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Diabetic Mellitus

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

12 y.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/25/78</u> , 19____ to <u>3/80</u> , 19____, that (I) (we) lost saw the deceased alive on <u>2/23/80</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) see the body after death.							
22b. SIGNATURE <u>Robert J. Lyden, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/25/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. Lyden, M.D.				22e. ADDRESS 6402 Golden Ring Rd., Balto., Md. 21237			

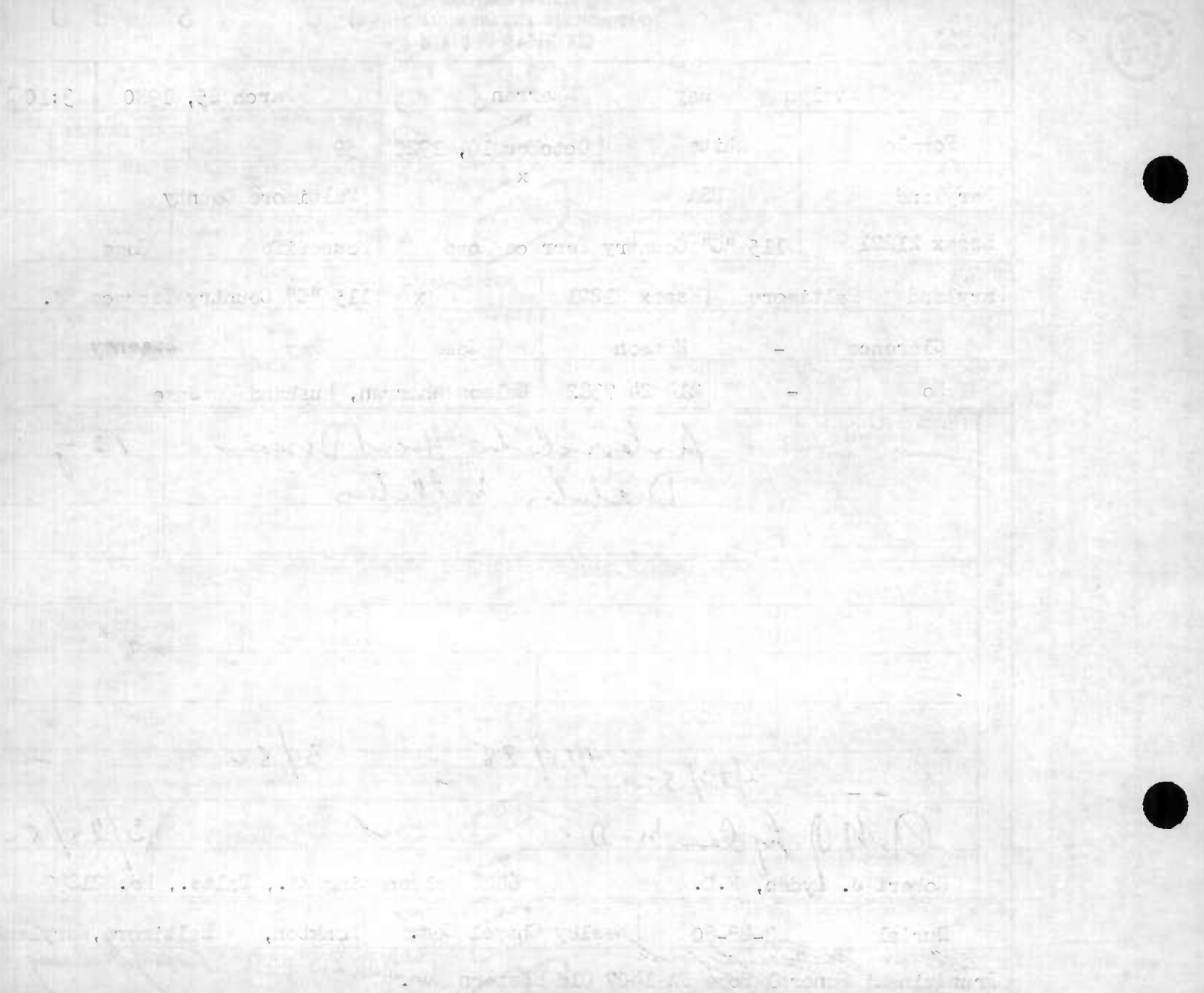
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-28-80		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Monkton, Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Bruzdzinski Funeral Home PA 1407 Old Eastern Ave.				25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 26 1980			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires: that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

006281

1- FOR  
STATE  
REGISTRAR

REG. NO.

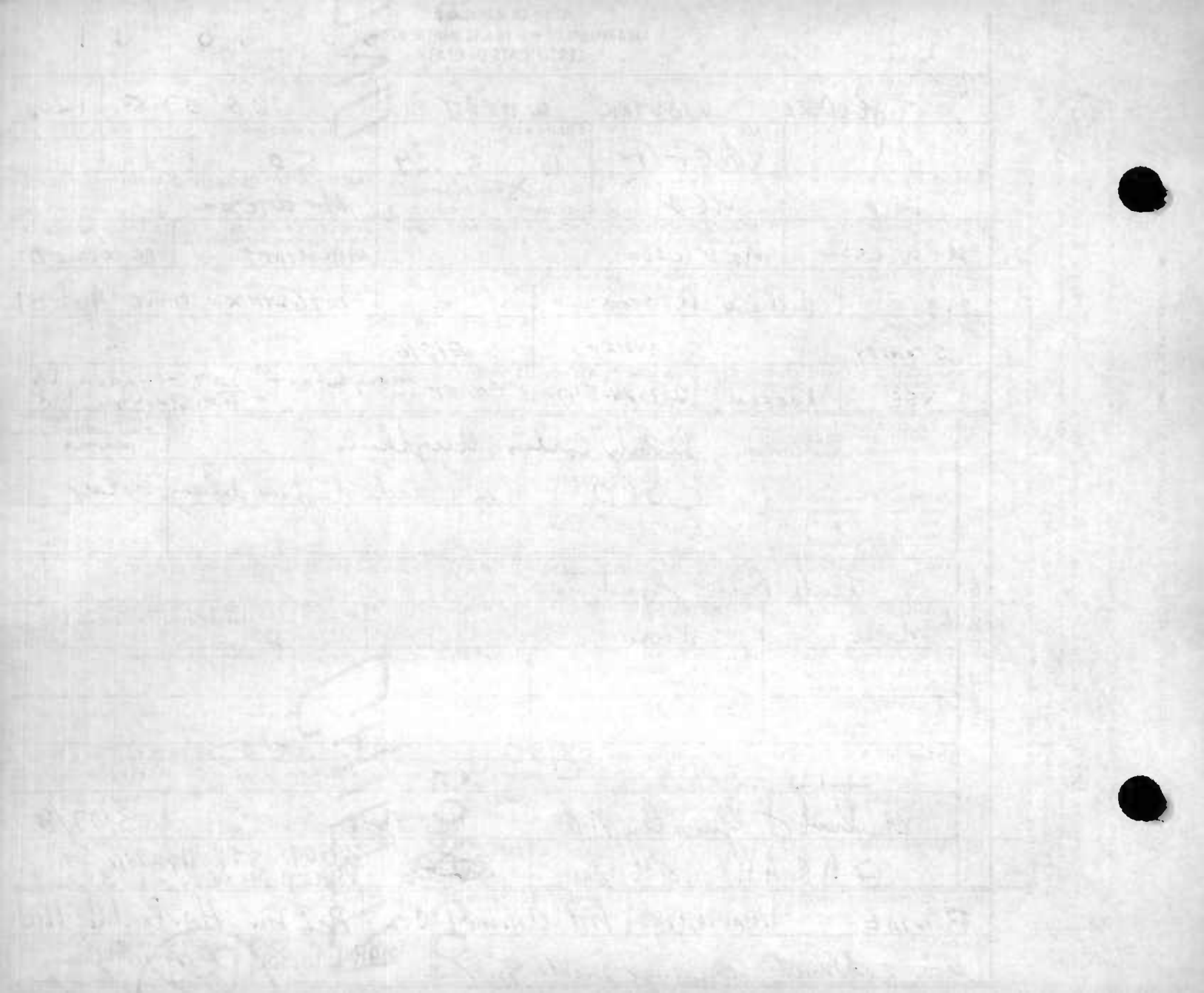
1. DECEASED NAME (TYPE OR PRINT) <b>THEODORE WALTER WHEAT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 07 80</b>		2b. HOUR <b>1200 PM</b>
3. SEX <b>M</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 3 29</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MO</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>H. Wilson Baltimore MD.</b>	
10. CITY OR TOWN OF DEATH <b>H. Wilson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MT. WILSON</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MACHINIST</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>ARMED SERVICES</b>
13a. STATE <b>MD</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>REISTERSTOWN</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>STANLEY WHEAT</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EISIE ?</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>KOREAN 217-26-5498</b>		17. INFORMANT <b>CHART. Mary Wheat</b> ADDRESS <b>107 Glyndon Dr. Reisterstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Cardiac Arrhythmia</b> <b>496-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <b>COPD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>21 acute Myocardial infarction</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>acute Brain Syndrome</b>					
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>03/06</b> , 19 <b>80</b> , to <b>03/07</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>03/06</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE <b>Michael J. Gueary MB</b>		DEGREE		22c. DATE SIGNED <b>03/07/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARY, M. K. L.</b>		22e. ADDRESS <b>3001 ST. HANOVER ST. BALTIMORE MD. 21230</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Mar. 10, 1980</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Carmel Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Harford Co. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>H. J. Eckhardt</b>		ADDRESS <b>Quinn's Smile Shop</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 11 1980</b>	
				25b. REGISTRAR'S SIGNATURE <b>Barry McGroady</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, complete retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		6 0 0 6 2 8 2					
1. DECEASED NAME (TYPE OR PRINT) Sue Bell White				2a. DATE OF DEATH MONTH DAY YEAR March 21, 1980				2b. HOUR 8:45 A.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Aug. 2, 1893		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. # UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.			
10 CITY OR TOWN OF DEATH Reisterstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1407 Nicodemus Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired School Teacher		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1407 Nicodemus Road	
14. FATHER'S NAME FIRST MIDDLE LAST William I. White		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan A. Beatley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES No		16b. SOCIAL SECURITY NO 214-40-4066		17 INFORMANT ADDRESS Mr. Glen Y. Shipley Pikesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - acute</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic CV Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>years</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 15</u> , 19 <u>77</u> , to <u>March 21</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>March 21</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>C. E. M. Williams MD</u>				DEGREE MD				22c. DATE SIGNED 3-21-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. E. M. Williams				22e. ADDRESS 11904 Reisterstown Rd Reisterstown Md. 21136					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 24, 80		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. 1			
24. FUNERAL DIRECTOR Eline Funeral Home Reisterstown, Md. 21136				25a. DATE REC'D. BY REGISTRAR MAR 26 1980		25b. REGISTRAR'S SIGNATURE <u>Jeffrey McNeely</u>			

Elise funeral home Reisterstown, Md. 21136

Burial Mar. 24, 80 Woodlawn Cemetery Baltimore, Md.

No

21A-45-4066 Mr. Glen Y. Shipley Timonville, Md.

William

I.

White

Swam

A.

Beasley

Md.

Balto.

Reisterstown

JACOY Nicholas Road

Reisterstown

JACOY Nicholas Road

Retired School Teacher

Balto. Md.

IRA

Baltimore Co.

Female

White

Mar. 2, 1897

86

2nd

Self

White

March 22, 1980

8:45 A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Wilder			FIRST MIDDLE LAST Baby Girl			2a. DATE OF DEATH MONTH DAY YEAR 3/28/80			2b. HOUR 12:45 AM
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 3 27 80		6 AGE (IN YEARS LAST BIRTHDAY) NB		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN 57	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Infant		12b. KIND OF BUSINESS OR INDUSTRY -	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD -			13b COUNTY -		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 2907 Bauernwood Ave. 21234
14 FATHER'S NAME FIRST MIDDLE LAST -			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Yvonne Wilder						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -			16b SOCIAL SECURITY NO -		17 INFORMANT ADDRESS Joan Wilder, grandmother, same address				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Intra <del>uterine</del> Hypoxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) Abruptio placenta PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from 3/27/80, 19_____, to 3/28/80, 19_____, that (I) (we) lost saw the deceased alive on 3/28/80, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Melchijah Spragins, M.D.			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/28/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melchijah Spragins, M.D.			22e. ADDRESS GBMC, 6701 N. Charles St. Balto. 21204						
23a. BURIAL, CREMATION, REMOVAL (SPRINKLING) Burial			23b. DATE 3/29/80		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24 FUNERAL DIRECTOR Brimdinek Funeral Home, Inc.			24b. ADDRESS 3331 Brehms Lane Baltimore, Md. 21213		25a. DATE REC'D. BY REGISTRAR APR 1 1980		25b. REGISTRAR'S SIGNATURE		



THE UNIVERSITY OF CHICAGO  
LIBRARY  
JAN 1 1964

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY  
JAN 1 1964



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 0 6 2 8 4

1. DECEASED NAME (TYPE OR PRINT) <b>EDDIE LEE WILLIAMS</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>12</b> YEAR <b>80</b>			2b. HOUR <b>1:00 p.m.</b>					
3 SEX <b>MALE</b>		4 RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>2</b> YEAR <b>97</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		7. IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.					
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VETERANS ADMINISTRATION MED. CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STEEL WORKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BETH. STEEL</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1302 MONTFORD AVENUE</b>					
14. FATHER'S NAME FIRST <b>THOMAS</b> MIDDLE <b>HENRY</b> LAST <b>WILLIAMS</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ROSA</b> MIDDLE <b>WILLIAMS</b> LAST <b>WILLIAMS</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>CLINICAL RECORDS VAMC FORT HOWARD, MD.</b>		ADDRESS					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> <b>515-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>INFECTED BULLAE BOTH LUNGS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PULMONARY FIBROSIS AND EMPHYSEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11a <b>MULTIPLE CARDIOVASCULAR ACCIDENT ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>July 3</b> , 19 <b>75</b> , to <b>March 12</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>March 12</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If signed and I did not view the body after death.)											
22b. SIGNATURE <i>Peter Juvan</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>3/13/80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER JUVAN, M. D.</b>				22e. ADDRESS <b>VA MEDICAL CENTER, FORT HOWARD, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-17-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MD Natl. Mem. Park</b>		23d. LOCATION CITY OR TOWN <b>Laurel</b> COUNTY <b>MD</b> STATE <b>MD</b>					
24. FUNERAL DIRECTOR NAME <b>Erickson Funeral Home - Caroline St.</b> ADDRESS <b>1129 N.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 14 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Patricia Halverson</i>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages to be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 4, 14, 3/24/80 gj

FOR Film G542 4/15/80  
1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 6 2 8 5  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Lucille WILLIAMS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 15, 1980</b>			2b. HOUR <b>1:00A</b> M					
3. SEX <b>Female</b>		4. RACE <b>Negro</b> <del>Female</del>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 20 28</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>838 N. Woodington Road</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Aaron Williams</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elnora Alston</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO <b>211-34-4437</b>		17. INFORMANT ADDRESS <b>Ransom Williams Sr. 838 N. Woodington</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>586- IMMEDIATE CAUSE (a). Renal failure; possible cancer of the pancreas</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Escherichia Coli sepsis; disseminated intravascular coagulation</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 26</b> 19 <b>80</b> , to <b>March 15</b> 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>March 15</b> 19 <b>80</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.											
22b. SIGNATURE <b>A. Clow</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>3-15-80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. Clow</b>			22e. ADDRESS <b>9000 Franklin Square Dr., 21237</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/22/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Family Plot</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Warrenton N.C.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>						ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 17 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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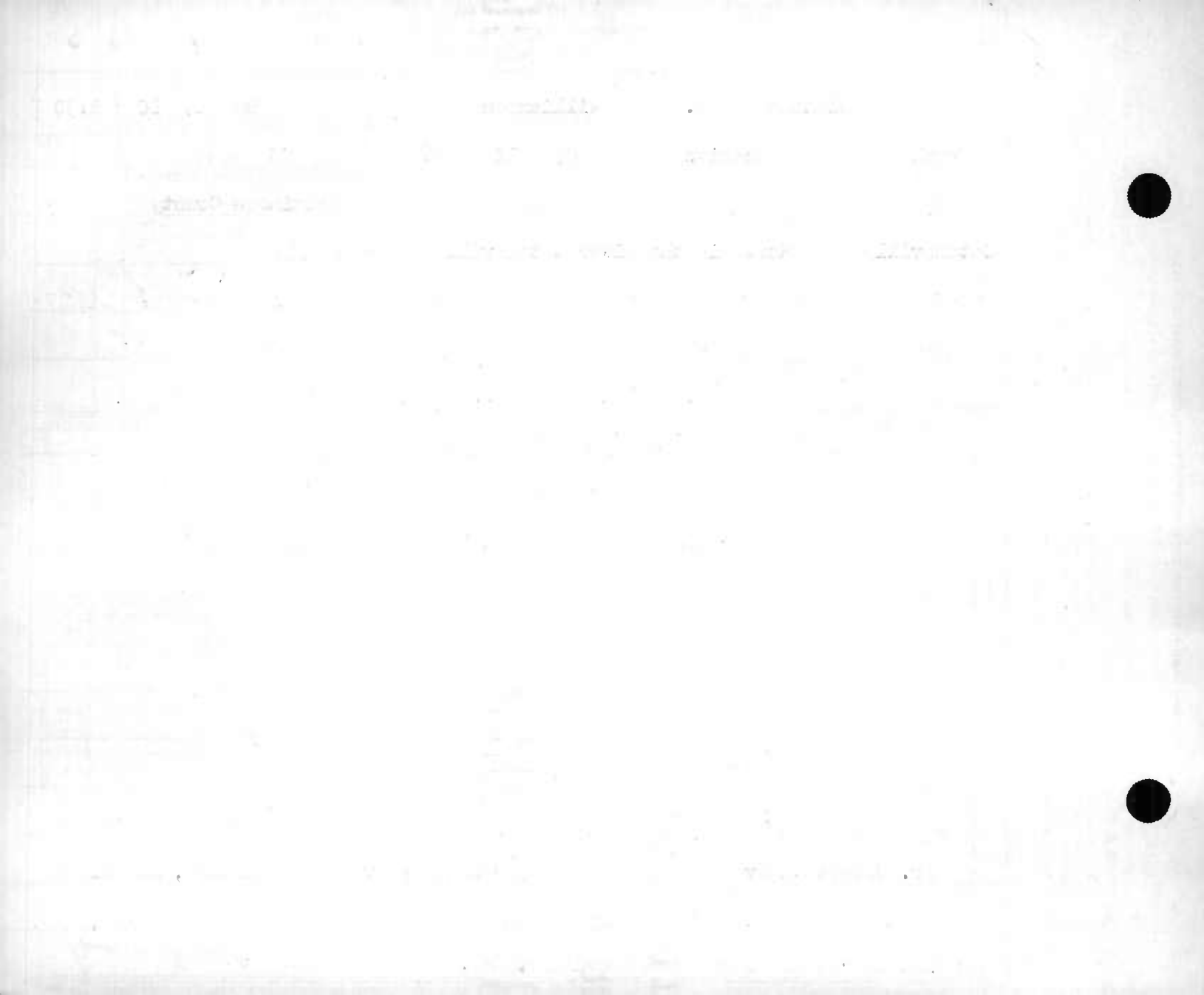
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
REG. NO. 8 0 0 6 2 8 6									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR A M	
Blanche L. Williamson						03 14 80		8:30 A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
Female		Caucasian		07 14 86		93 YRS		MONTHS DAYS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maine		USA				Baltimore County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville		House in the Pines Catonsville				Housewife		Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS			
Maryland		Baltimore		Lansdowne		802 Fifth Avenue 21227			
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Frank Stroute					Annie Laurie Allen				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
No					N/A				
17. INFORMANT ADDRESS					17. INFORMANT ADDRESS				
Mrs. Doris Nagel Same as # 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) Sudden death									
4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASIDS - evb - Serial delirium									
DUE TO, OR AS A CONSEQUENCE OF (c) old fx. R-L hip. Ectropion Bilateral									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 5-21-75, 19, to 3-14-80, 19, that (I) (we) last saw the deceased alive on 3-14-80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE					DEGREE			22c. DATE SIGNED	
Dr. George Angov					Attending Physician			3-14-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Dr. George Angov					3350 Wilkens Avenue Baltimore, MD 21229				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			3/17/80		Meadowridge Mem Pk		Elkridge Howard, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
MacNabb Funeral Home Catonsville, Md.					MAR 24 1980		[Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <b>LILLIAN MARIE WILLNECKER</b>					2a. DATE OF DEATH MONTH <b>3</b> DAY <b>7</b> YEAR <b>80</b>		2b. HOUR <b>10:20</b> a					
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH <b>3</b> DAY <b>31</b> YEAR <b>1892</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.						
10 CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1821 Belle Avenue</b>			
14 FATHER'S NAME FIRST <b>John</b> MIDDLE <b></b> LAST <b>Basom</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Beatrice</b> MIDDLE <b></b> LAST <b>Casey</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO <b>171-07-6970</b>		17 INFORMANT <b>Ethel M. Steele</b>		ADDRESS <b>7421 School Ave. Balto. MD 21222</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory arrest</b> <b>5183</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bilateral Lung Infiltrates</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Dehydration; Senility</b>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2/26/80</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>2/26/80</b> , 19 <b>80</b> , to <b>3/7/80</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>3/7/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Raul Masvidal, M.D.</b> DEGREE <b>MD</b>										22c. DATE SIGNED <b>3/7/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Raul Masvidal, M.D.</b>						22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/10/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Baltimore, MD</b>				
24 FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 11 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

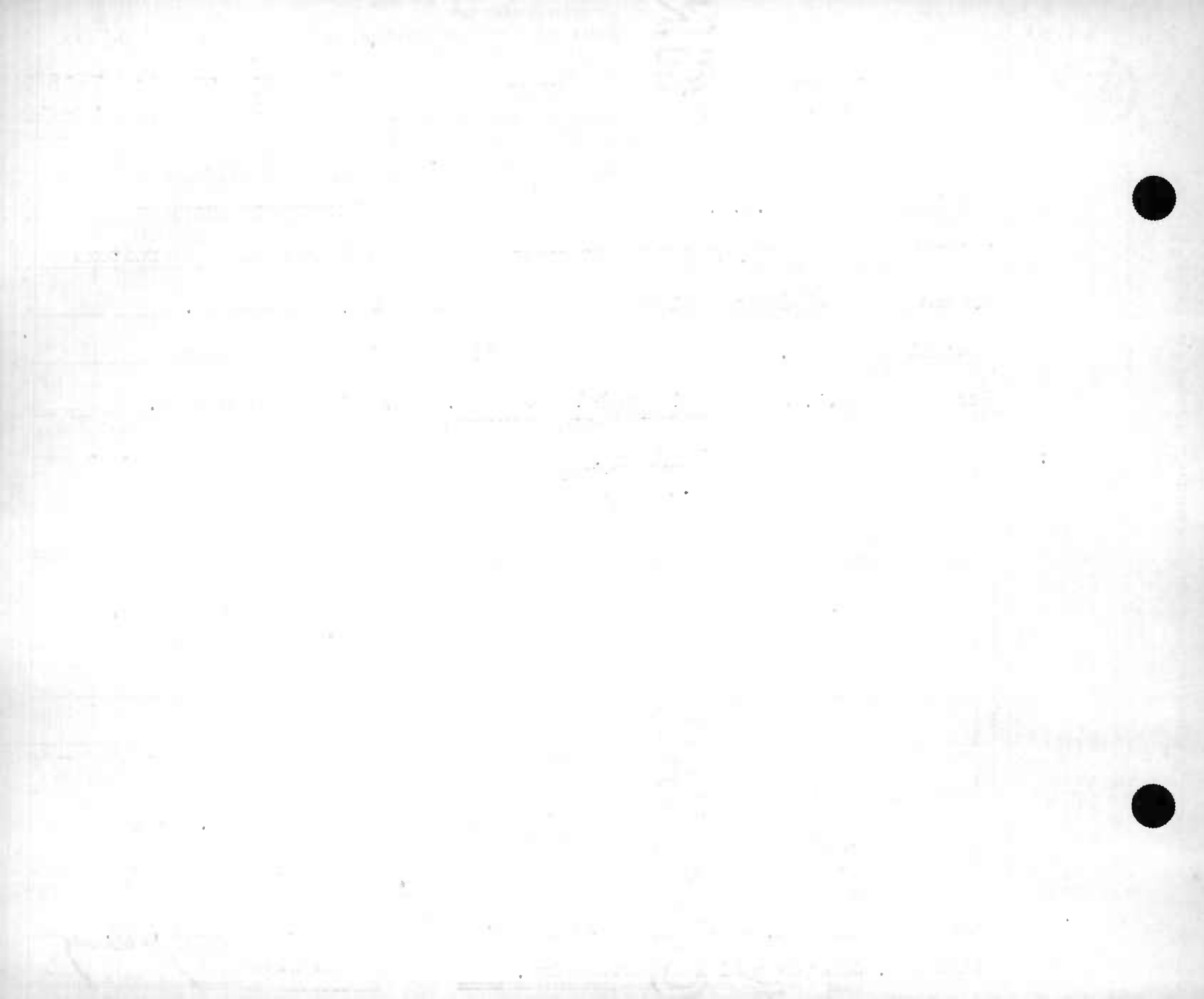


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																
1. DECEASED NAME (TYPE OR PRINT) <b>HUNLEY E. WILSON</b>					2a. DATE OF DEATH MONTH <b>03</b> DAY <b>25</b> YEAR <b>80</b>					2b. TIME OF DEATH <b>7:58 PM</b>						
3. SEX <b>MALE</b>			4. RACE <b>CAUC</b>			5. DATE OF BIRTH MONTH <b>7</b> DAY <b>24</b> YEAR <b>11</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS			7. IF UNDER 1 YEAR MONTHS <b>03</b> DAYS <b>25</b>		8. IF UNDER 24 HRS HOURS <b>07</b> MIN <b>58</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>							
10. CITY OR TOWN OF DEATH <b>TOWSON</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cabinetmaker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>				
13a. STATE <b>Maryland</b>			13b. CITY <b>Baltimore</b>			13c. CITY OR TOWN <b>21234</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>1707 Aberdeen Rd.</b>				
14. FATHER'S NAME FIRST <b>Samuel</b> MIDDLE <b>E.</b> LAST <b>Wilson</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Carrie</b> MIDDLE <b>Hunley</b> LAST <b></b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>						16b. SOCIAL SECURITY NO. <b>W.W. II 213-05-5812</b>			17. INFORMANT ADDRESS <b>Naomi L. Wilson 1707 Aberdeen Rd.</b>							
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> <b>492- EMPHYSEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>EMPHYSEMA</b> (c) <b>21MPHYSEMA</b>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>2/26</b> , 19 <b>80</b> , to <b>3/25</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>3/25</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)																
22b. SIGNATURE <b>Charles B. Hutton</b>										DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/25/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES B. HUTTON</b>										22e. ADDRESS <b>7600 OSKER DR, TOWSON, MD 21204</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>3/28/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County MD</b>						
24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b>										ADDRESS <b>8521 Loch Raven Blvd.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1980</b>			25b. REGISTRAR'S SIGNATURE <b>John J. McNeely</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 0 6 2 8 9			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
John J. Winkler				3 1 80 9 p. M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		4 23 1892		87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Balto. Co. Md.		U. S. A.				Baltimore County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		St. Joseph Hospital		Farming		Self-Employed	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Baltimore		Glen Arm		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
Jacob Winkler		Caroline Luskorn		12005 Manor Rd. Glen Arm, Md. 21057			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		212-01-3375		Glen Arm, Md. 21057			
				Mrs. Eileen M. Carlson, 11816 Manor Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Colon with Pulmonary Metastasis</b> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) this hospital attended the deceased from 2/23/80, 1980, to 3/1/80, 1980, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE A. M. GHILADI, MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-2-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
A. M. GHILADI, MD		7620 York Road		Towson MD 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		3-5-1980		St. Johns Ch. Cem.		Long Green Balto. Md.	
24. FUNERAL DIRECTOR NAME E. F. Lassahn, 11750 Belair Rd. ADDRESS Kingsville, Md. 21087				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				MAR 10 1980		P. H. McCreedy	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 8006290									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELEANORA B WITKOWSKY						2a. DATE OF DEATH MONTH DAY YEAR MARCH 20, 1980		2b. HOUR 12:55A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 11, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Baltimore						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3135 Weaver Ave	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Balcer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Anna Kazmierczak					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-07-0817		17. INFORMANT ADDRESS Mrs Bernadette Younghans 5510 Greenfield av					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Shock</u> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Infected Pyruvic graft</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetic Mellitus</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Ketoacidosis, Renal Insufficiency</u>									
19a. DATE OF OPERATION 3/19/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Infected Pyruvic graft				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital attended the deceased from <u>MARCH 13, 1980</u> to <u>MARCH 20, 1980</u> , that (we) last saw the deceased alive on <u>MARCH 20, 1980</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) did not view the body after death.									
22b. SIGNATURE <u>Samuel M. Donia</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3/20/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL M. DONIA				22e. ADDRESS St. Joseph Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/24/80		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc.				ADDRESS Baltimore, Maryland		15a. DATE REC'D. BY REGISTRAR MAR 21 1980		15b. REGISTRAR'S SIGNATURE <u>Patricia Halverson</u>	

GENERAL INFORMATION	IDENTIFICATION	CLASSIFICATION
1. NAME (Last, First, Middle Initial)	2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH
4. CURRENT ADDRESS	5. PREVIOUS ADDRESSES	6. OCCUPATION
7. EDUCATION	8. MILITARY SERVICE	9. CRIMINAL RECORD
10. EMPLOYMENT HISTORY	11. FOREIGN TRAVEL	12. REFERENCES
13. MARITAL STATUS	14. CHILDREN	15. SIGNATURE
16. DATE OF INTERVIEW	17. INTERVIEWER	18. AGENCY
19. COMMENTS	20. SIGNATURE	21. DATE
22. COMMENTS	23. SIGNATURE	24. DATE
25. COMMENTS	26. SIGNATURE	27. DATE
28. COMMENTS	29. SIGNATURE	30. DATE
31. COMMENTS	32. SIGNATURE	33. DATE
34. COMMENTS	35. SIGNATURE	36. DATE
37. COMMENTS	38. SIGNATURE	39. DATE
40. COMMENTS	41. SIGNATURE	42. DATE
43. COMMENTS	44. SIGNATURE	45. DATE
46. COMMENTS	47. SIGNATURE	48. DATE
49. COMMENTS	50. SIGNATURE	51. DATE
52. COMMENTS	53. SIGNATURE	54. DATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. FOR STATE REGISTRAR												
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE CHARLES WOLF, SR.					2a. DATE OF DEATH MONTH DAY YEAR March 3, 1980					2b. HOUR M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 10, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 65		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.						
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Manager		12b. KIND OF BUSINESS OR INDUSTRY W.L. Reynolds Co.				
13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 900 Southwick Drive	
14. FATHER'S NAME FIRST MIDDLE LAST George Andrew Wolf					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Wissmann							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-01-5384		17. INFORMANT ADDRESS Mrs. Emma M. Wolf 900 Southwick Drive						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>59</u> , to <u>March 3</u> , 19 <u>80</u> , that (I) <u>(saw)</u> lost saw the deceased alive on <u>1/19</u> , 19 <u>80</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(did not)</u> view the body after death.												
22b. SIGNATURE <u>Kevin Quinn</u>						DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/4/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kevin Quinn, M.D.						22e. ADDRESS 1205 York Road						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-6-1980		23c. NAME OF CEMETERY OR CREMATORY Loudon Park			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland				
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Maryland						25a. DATE REC'D. BY REGISTRAR MAR 4 1980			25b. REGISTRAR SIGNATURE <u>Robert McCreedy</u>			



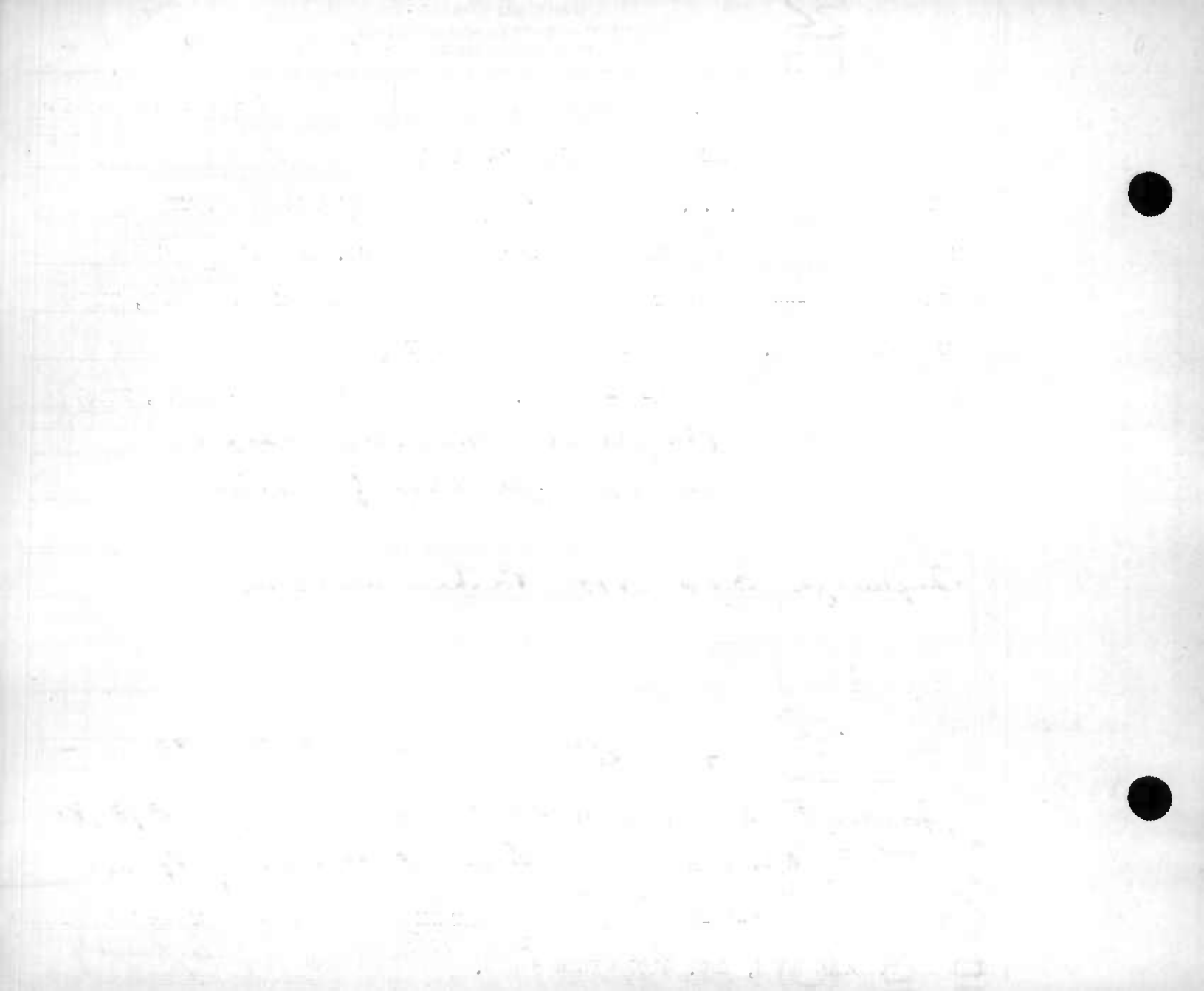
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 8 0 0 6 2 9 2									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
SMALLWOOD L. WOLFE						03 07 80			6:55 PM		
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
MALE		WHITE		06 24 1892		87 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND			U.S.A.						BALTIMORE COUNTY MD.		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
CATONSVILLE			SUMMIT NURSING HOME			SUP. OF MAIN			G & E		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
MARYLAND			---		BALTIMORE				SERVICE 131 NORTH BEND ROAD, 21229		
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
TOWNLEY R. WOLFE			SIDNEY LEAF			NO			212-05-6754		
17 INFORMANT ADDRESS			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c) DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
S. LEIGH WOLFE 7203 DIANA PLACE, 21207			4292 <i>Pericardial vascular collapse</i>								
			ASCD with atrial fibrillation								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<i>Influenza Old CVA, Parkinsonism</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>12/21</i> 19 <i>76</i> to <i>3/7</i> 19 <i>80</i> , that (I) <del>was</del> last saw the deceased alive on <i>3/7</i> 19 <i>80</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>have</del> (did) <del>not</del> view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
<i>James E. Rowe MD</i>			<i>MD</i>						<i>3/8/80</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
<i>J. E. ROWE</i>			<i>Summit Nursing Home</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL			03-10-80		LORRAINE PARK			WOODLAWN BALTIMORE MARYLAND			
24 FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
HUBBARD FUNERAL HOME, INC.			4107 WILKENS AVE.			MAR 11 1980			<i>Fitzroy Kennedy</i>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										06293 REG. NO.	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT EUGENE WRIGHT, SR.</b>										2b. DATE KNOWN OF DEATH ESTIMATED <b>3 3 1980</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>4/14/1897</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>82 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>3 4 1980</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>					
10. CITY OR TOWN OF DEATH <b>Dundalk</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2713 Dunwood Ct.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Liquor Distr.</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2713 Dunwood Ct. 21222</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank A. Wright, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216.09.1180</b>		17. INFORMANT ADDRESS <b>Robert E. Wright, Jr. 2908 Dunbrin Ct. C Dundalk, Md. 21222</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute intracerebral hemorrhage</b> <b>431-</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>J. Crossan O'Donovan</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>3/4/80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>J. Crossan O'Donovan</b>				ADDRESS <b>212 DUNDALK AVE, BALTO, MD 21222</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>3/6/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Walter Brooks Bradley Inc. Dundalk, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 10 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Robert E. Wright, Jr.</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

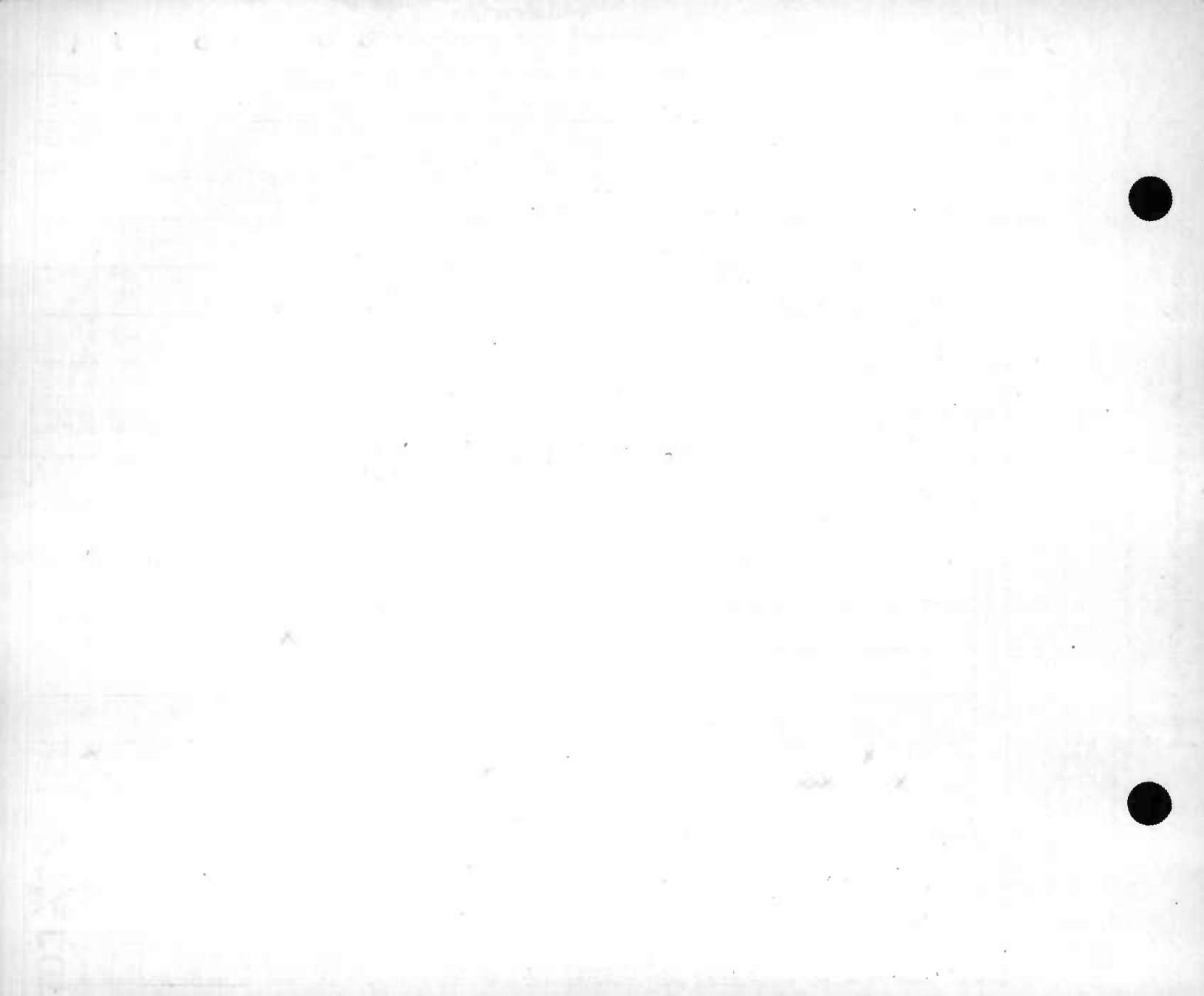
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)				3. DATE OF DEATH MONTH DAY YEAR		4. HOUR	
		FIRST CATHERINE		MIDDLE A.		LAST YOUNGER		MARCH 20, 1980 1:50p.m.	
5. SEX Female		6. RACE White		7. DATE OF BIRTH MONTH DAY YEAR April 12, 1916		8. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		9. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		13. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
14. CITY OR TOWN OF DEATH TOWSON		15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL				16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		17. KIND OF BUSINESS OR INDUSTRY	
18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
19a. STATE Maryland		19b. COUNTY Baltimore		19c. CITY OR TOWN Towson		19d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19e. STREET ADDRESS 6920 Donachie Rd	
20. FATHER'S NAME FIRST MIDDLE LAST William Schmitt				21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Koubeck					
22a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		22b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-09-9245		23. INFORMANT ADDRESS Mr Allen L Younger 14 Dendron Ct 21234					
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of lung, oat cell type, with metastases 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
25a. DATE OF OPERATION		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED				25c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		25d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
26a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		26b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		26c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
27a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		27b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		27c. LOCATION STREET CITY OR TOWN COUNTY STATE					
28. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 3, 19 80, to March 20, 19 80, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on March 20, 19 80, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.									
29a. SIGNATURE Natividad D. de Leon, M.D.				29b. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				29c. DATE SIGNED 3/20/80	
30a. PHYSICIAN'S NAME (TYPE OR PRINT) Natividad D. de Leon, M.D.				30b. ADDRESS 7620 York Road, Towson, MD 21204					
31a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		31b. DATE 3/24/80		31c. NAME OF CEMETERY OR CREMATORY Moreland Mem Park		31d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
32. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland				33. DATE REC'D. BY REGISTRAR MAR 21 1980		34. REGISTRAR'S SIGNATURE [Signature]			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO. 8 0 0 6 2 9 5							
1. DECEASED NAME (TYPE OR PRINT) <b>Stanley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 23, 1980</b>			2b. HOUR <b>11:50 PM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 4, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		7. # UNDER 1 YEAR MONTHS DAYS <b>11</b> MONTHS <b>5</b> DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Baker-Herman's Bakery</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7623 Spruce Road 21222</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Zakrzewski</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Marchefka</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-07-3863</b>		17. INFORMANT ADDRESS <b>Helen Zakrzewski (same as line 13)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>7991</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Metastatic Carcinoma of Liver</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <b>March 18</b> , 19 <b>80</b> , to <b>March 23</b> , 19 <b>80</b> , that (we) last saw the deceased alive on <b>March 23</b> , 19 <b>80</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.										
22b. SIGNATURE <i>Edward Suarez</i>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>3-23-80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edward Suarez M.D.</b>					22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/27/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck, Inc., Baltimore, Maryland</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony McCready</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		70. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		REG. NO.	
I. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		ZENTZ		March 11, 1980		540 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
Female		White		Feb. 11, 1911		69 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Maryland		U.S.A.				Baltimore Co.,			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Randallstown		Baltimore County Gen. Hospital		Bookkeeping		Dept. Store			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1313A E. Belvedere Ave.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
E. Watkins		Emma A. Driver		No		215-09-5372		James Hingeley, 912 Locust Ave. ADDRESS	
								Charlottesville, Va. 22901	
II. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <u>Ventricular Tachycardia</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/1</u> 19 <u>77</u> to <u>3/11</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3/11</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
<u>B. A. Cochran M.D.</u>				3/11/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
B. A. Cochran M.D.		6506 Park Heights Ave. Balt, Md 21215							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Mar. 14, 1980		Crest Lawn		Marriottsville, Howard, Md.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Olin L. Molesworth		Damascus, Md.		MAR 17 1980		<u>Robert M. Brady</u>			

March 11, 1960

Warfield

Feb. 11, 1961

White

Female

Baltimore Co.,

U.S.A.

Barling

Bookeeping

Baltimore County Gen. Hospital

Barling

1913A E. Belvedere Ave.

x

Baltimore

Barling

Driver

Barling

Barling

Barling

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915 Locust Ave.  
Charlottesville, Va. 22901

215-04-5372

no

Charlottesville, Va.

Feb. 11, 1960

Barling

Chas. L. Barling, Barling, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0000BP

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 6 2 9 7  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MAR. 26, 1980		7a. M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
F		W		MONTH DAY YEAR		80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MD.		USA				BALTO. MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALOWIN		BCX 13120 FORK RD.		HSE			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD		BALTO		BALWIN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
JOSEPH		UNIK		NO		UNK	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 4292		19. DATE OF OPERATION		20. AUTOPSY?	
ADAM ZIEGEL		Cerebral Hemorrhage		Jan 29, 1960		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ADDRESS ABOVE		DUE TO, OR AS A CONSEQUENCE OF (b). Arterio Cardiovas Dis.		Ca. ht. heart - 1960		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		DUE TO, OR AS A CONSEQUENCE OF (c).				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
Ca. ht. heart - 1960							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		22a. I certify that (I) (this hospital) attended the deceased from Jan 20, 1960, to Mar 26, 1980, that (I) (we) last saw the deceased alive on 3/26, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22b. SIGNATURE	
						CLIFFORD F. HUDSON MD	
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS		22e. DATE SIGNED		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
CLIFFORD F. HUDSON		12648 FORK RD.		3/28/80			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		3/29/80		SACRED HEART OF MARY		BALTO. MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR	
J.G. CONNELLY		APR 3 1980		L. J. KERN			



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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8006298							
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST PAUL EUGENE ZIMMER				2a DATE OF DEATH MONTH DAY YEAR 3 18 80		2b HOUR 1:10 a.m.	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5 23 31		6 AGE (IN YEARS LAST BIRTHDAY) 48		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		9b CITIZEN OF WHAT COUNTRY? U S A		9 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.			
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC BALTIMORE, MARYLAND 21218				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stationary Engineer		12b KIND OF BUSINESS OR INDUSTRY Brewery	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND		13b COUNTY		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 1225 HOLLINS ST.	
14 FATHER'S NAME CHARLES		MIDDLE H.		LAST ZIMMER		15. MOTHER'S MAIDEN NAME FIRST ETHEL		MIDDLE MARSHALL	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) KOREAN		17 INFORMANT Sandra L. Zimmer		ADDRESS 838 Pear St. Reading, Pa.		19601	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypoxemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Squamous cell Cancer of lung</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>Several hours</u> <u>Several years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Paraplegia</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>3/16</u> 19 <u>80</u> , to <u>3/18</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>1 AM 3/18</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Laurence Austin Doyle md</u>		DEGREE md				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <u>3/18/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LAURENCE Austin Doyle md</u>		22e ADDRESS							
23a BURIAL, CREMATION, REMOVAL (SECURE) <u>Burial</u>		23b DATE <u>March 21, '80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ravine Cemetery</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>Pine Grove, Pennsylvania</u>			
24 FUNERAL DIRECTOR NAME <u>William E. Johnson</u>		ADDRESS <u>8521 Loch Raven Blvd.</u>				25a. DATE REC'D. BY REGISTRAR <u>MAR 20 1980</u>		25b. REGISTRAR'S SIGNATURE <u>L. J. Halbrudy</u>	

PAUL EUGENE EIGHT 3 10 10 1:10

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NEWSPAPER

U S A

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WILLIAM W. WILSON, WILSON'S

WILLIAM W. WILSON, WILSON'S

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WILLIAM W. WILSON, WILSON'S

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WILLIAM W. WILSON, WILSON'S

WILLIAM W. WILSON, WILSON'S

WILLIAM W. WILSON, WILSON'S

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
GRACE		NMN		ZULOUF				MARCH 29, 1980		9:45 <sup>A</sup>	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
FEMALE		White		March 7, 1890		90 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				BALTIMORE COUNTY				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
TOWSON		GREATER BALTO. MEDICAL CTR.		Housekeeper		Domestic					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Baltimore		Sparks				1433 Sparks Road			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Louis		Zulouf		Josephine		Middendorf					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No		220-54-8409		Miss Virginia Irene Zulouf		1433 Sparks Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> <u>4280</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>MARCH 6</u> , 19 <u>80</u> , to <u>MARCH 29</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (I) (we) lost saw the deceased alive on above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
								1-5/27/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		3/31/80		Jessups UM Ch. Cem.		Cockeysville, Baltimore, Md.					
24. FUNERAL DIRECTOR NAME Martin D. Lawson 10 W. Padonia Rd. Timonium				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE				MAR 31 1980			

GRACE

WOLFE

MARCH 29, 1930 3:45

FEMALE

BALTIMORE COUNTY

TOWSON

GREATER BALTO. MEDICAL CTR.

CARDIO PULMONARY ARREST  
CONGESTIVE HEART FAILURE

MARCH 29 1930

MARCH 29 1930

MARCH 29 1930

2/5/30

*[Handwritten signature]*